wooster ob•gyn

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Name _____ Date of Birth _____
Last First Initial Maiden Name

Parent Name (if under 18) _____Parent Social Security # _____

Your Current Occupation _____Spouse Occupation _____

1. Do you have or have you ever had any of the following symptoms, diagnoses, or procedures?

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
Crushing Chest Pain	□	□	Severe Back Pain	□	□	Extreme Forgetfulness	□	□
Irregular Heart Rhythm	□	□	Spina Bifida	□	□	Multiple Sclerosis	□	□
Cardiac Catheterization	□	□	Paralysis	□	□	Epilepsy or Seizures	□	□
Bypass Surgery	□	□	Arthritis	□	□	Deafness	□	□
Congestive Heart Failure	□	□	Frequent Wheezing	□	□	Hemophilia	□	□
Pacemaker	□	□	Emphysema	□	□	Von Willebrand Disease	□	□
Other Heart Problems	□	□	Asthma	□	□	Venous Blood Clots	□	□
Diabetes	□	□	Depression	□	□	AIDS/ARC	□	□
High Blood Sugars	□	□	Attempted Suicide	□	□	Hepatitis or Jaundice	□	□
Cancer or Leukemia	□	□	Other Mental Disorder	□	□	High Blood Pressure	□	□
Ulcerative Colitis	□	□	Anorexia or Bulimia	□	□	Stroke	□	□
Ulcers	□	□	Alcohol Dependency	□	□	Excessive Scarring	□	□
Crohn's Disease	□	□	Drug Dependency	□	□	Severe Anesthesia Rxn.	□	□
Diverticulitis	□	□	Sexually Transmitted Disease	□	□	Other _____		

2. Reason for Today's Visit _____

3. Please list all serious medical illnesses and dates (i.e. diabetes, liver/kidney disease, cancers, etc.):

4. Current Medications and Dosages:

5. Birth Control (Please check one or more):
   - □ None-Not trying to avoid pregnancy
   - □ Menopause
   - □ Birth Control Pills
   - □ Partner had Vasectomy or Hysterectomy
   - □ Abstinent or Not Sexually Active
   - □ Natural Family Planning
   - □ Prior Tubal

6. Have you ever smoked? □ Yes □ No
   Do you smoke now? □ Yes □ No
   Year you quit smoking (if applies): _____
   If you smoke now, how many packs/day?_____

7. Please indicate the Number of:
   Term pregnancies _____ Preterm pregnancies_____
   Miscarriages _____ Abortions_____

8. Has anyone in your immediate family (mother, father, sibling, grandparent, or child) ever had:
   - □ Breast Cancer □ Colon Cancer
   - □ Ovarian Cancer □ Heart Disease
   - □ Uterine Cancer □ Diabetes

9. Prior Surgeries and Year Performed:

10. Last date of following studies and results:

	Date	*Normal*	*Abnormal*	*Abnormal In Past*
Pap smear	_____	□	□	□
Mammogram	_____	□	□	□
Colonoscopy	_____	□	□	□
DEXA	_____	□	□	□

11. Drug allergies and type of reaction to each drug: