

**Medical History**

**Account #** \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

e-mail \_\_\_\_\_ Marital Status \_\_\_\_\_

Social Security# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Family Physician \_\_\_\_\_ Ref by \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Religion \_\_\_\_\_ Emergency Contact# \_\_\_\_\_

Emergency Contact Name / Relationship \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Are you against a blood transfusion in an emergency situation? \_\_\_\_\_

If yes, why? \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's social securtiy# \_\_\_\_\_

If you are 18 or a student, give parent information

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Social Security# \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Social Security# \_\_\_\_\_

Can we contact your parents regarding insurance information? \_\_\_\_\_

Are you covered under your parent's Insurance? \_\_\_\_\_

List all insurance companies that you are currently covered under

Health Insurance Co	Policy #	Name of Insured	Date of Birth

**Authorization to release information and assignment of benefits:**

I hereby authorize Spartanburg & Pelham OB-GYN to furnish information to my insurance carriers concerning my condition and/or treatment, and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

\_\_\_\_\_  
 Date Signature of Patient Parent's signature (if minor)



**Check if you have had any of the following illnesses**

	Yes	No	Don't Know
Allergies			
Amputations (any)			
Anemia			
Ankylososis (stiff / frozen joints)			
Arteriosclerosis			
Arthritis			
Asthma			
AIDS / HIV			
Back Problems			
Blood Clots			
Brain Damage			
Bronchitis			
Cerebral Palsy			
Cerebral Vascular Accident (stroke)			
Chicken Pox			
Chronic Cough			
Colds (frequently)			
Colitis			
Deafness			
Diabetes			
Ear Problems			
Emphysema			
Epilepsy			
Fainting or Dizzy Spells			
Foot Problems			
German Measles			
Headaches (frequently?)			
Heart Problems			
Hemophilia			
Hepatitis			
Hernia			
Hypertension			
Hodgkins Disease			
Hypoglycemia			
Jaundice			
Kidney Conditions			
Loss of Sight			
Measles			
Mental Retardation			
Multiple Sclerosis			
Mumps			
Muscular Dystrophy			
Osternylitis			
Parkinson's Disease			
Peptic Ulcer			
Pneumona			
Poliomyelitis			
Psychological Problems			
Rheumatic Fever			
Ruptured Disc (back or neck)			
Shortness of Breath			
Sinus Problems			
Skin Rashes or Infections			

**Check if you have had any of the following illnesses (continued)**

	Yes	No	Don't Know
Sore Throats (frequently)			
Swelling of Legs and Ankles			
Thrombophlebitis			
Tuberculosis			
Typhoid Fever			
Varicose Veins			
Other - Explain			
Other - Explain			

**Family History (Do not indicate your husband's history)**

	Age	Living	Deceased	Cause of Death	If living how is health?
Father					
Mother					
Brothers					
Sisters					

Place an X by any of the following illnesses which have affected any near relative, and label as follows:  
**M**=Mother, **F**=Father, **MGM**=Maternal Grandmother, **PGF**=Paternal Grandfather, **A**=Aunt, ect.

Tuberculosis	_____	Heart Attacks	_____
Epilepsy	_____	Kidney Disease	_____
Cancer	_____	Other	_____
Diabetes	_____		_____
High Blood Pressure	_____		_____

How old were you when you first started to menstruate? \_\_\_\_\_

Are your periods regular? Yes No Circle one

How far apart are they? \_\_\_\_\_ days

How many days do they last? \_\_\_\_\_

Is the flow excessive, normal or scanty? \_\_\_\_\_

Do you have any discomfort with your periods? Yes No

What was the date your last period began? \_\_\_\_\_

Do you ever bleed or spot between periods? \_\_\_\_\_

Do you have hot flashes or other symptoms of menopause? Yes No

Have you ever taken female hormones? Yes No

Have you had any vaginal bleeding since menopause? Yes No

Have you ever had a bone density test since menopause? Yes No

Do you ever have a vaginal discharge? Yes No Frequently? Yes No

Do you sometimes lose control of your bladder when you cough or sneeze? Yes No

Date of your last Pap Smear \_\_\_\_\_ Results \_\_\_\_\_

What year was your last Diphtheria/Tetanus Booster? \_\_\_\_\_

When was your last Mammogram? \_\_\_\_\_ Results \_\_\_\_\_

When was your serum cholesterol checked? \_\_\_\_\_ Results \_\_\_\_\_

If over age 50, when was your last Colonoscopy? \_\_\_\_\_ Results \_\_\_\_\_

If over age 50, when was your last Sigmoidoscopy? \_\_\_\_\_ Results \_\_\_\_\_

What type of contraceptive do you use? \_\_\_\_\_

Have you ever been diagnosed with a sexually transmitted disease? Yes No

If so, please list \_\_\_\_\_