ASHMED VÁZQUEZ MD, PC
OBSTETRICS AND GYNECOLOGY

Personal Health History

Patient Name ____ Date___________________

INITIAL INFORMATION

Number of Pregnancies ________ Number of Deliveries_________ Term_______ Pre-term________

Race____________________ Sexually Active? Yes____ No ____

Last Menstrual Period____________________

REASON FOR VISIT

Well women visit ____ Urinary incontinence/Pelvic relaxation ____ Breast lump or mass ____

Contraceptive Refill ____ DepoProvera Injection ____ Menopausal Symptoms ____

Menstrual Disorders ____ Pelvic Pain____ Urinary tract symptoms ____ Vaginal Discharge ____

Vulvar Lessions _____ Pregnancy ____ Follow Up ____ Other __________________________

ALLERGIES: List all allergies

____

____

CHILDHOOD ILLNESS

Chicken Pox ____ Measles ____ Mumps ____ Rheumatic Fever ____ Rubella ____

SURGERIES: List all surgeries

____

____

TRANSFUSIONS: Yes ____ No____

SMOKING STATUS

Current Every Day Smoker ____ Current Some Day Smoker ____

Former Smoker ____ Never Smoker ____

ALCOHOL USE

No ____ Yes ____ If Yes, how much? Every Day ____ Occasional ____ Social ____

DRUG USE

No ____ Yes____ If Yes, which? Cocaine ____ Marijuana ____ Prescription Drugs ____

Other ____

CURRENT METHOD OF BIRTH CONTROL

Barrier Methods (Condoms, Diaphragm) ____ Tubal Ligation ____ Depo Provera ____

IUD Mirena ____ IUD Para Gard ____ Nuva Ring ____ Birth Control Pills ____ Vasectomy ____

GYNECOLOGICAL HISTORY

Menarche (First period) ______________ Cycle Frequency _______________ How Many Days?_______

Volume of Menses: Light ____ Moderate ____ Heavy ____

Last PAP Smear _____________________ Last Mammogram __________________

Pelvic Inflammatory Disease (PID)? Yes ____ No ____

Sexually Transmitted Disease? Yes____ No_____

If Yes, which? ____

MEDICATIONS: List medications and over the counter drugs you are currently using.

Medication	Dosage	How often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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MEDICAL HISTORY:

HEALTH ISSUES	YOU?		FAMILY MEMBERS?		WHICH FAMILY MEMBER?
ABNORMAL UTERINE BLEEDING	YES	NO	YES	NO	
ANEMIA	YES	NO	YES	NO	
BLOOD DISORDERS	YES	NO	YES	NO	
BLOOD TRANSFUSIONS	YES	NO	YES	NO	
BREAST DISEASE	YES	NO	YES	NO	
BRONCHIAL ASTHMA	YES	NO	YES	NO	
CANCER	YES	NO	YES	NO	
CHRONIC HYPERTENSION	YES	NO	YES	NO	
DIABETES	YES	NO	YES	NO	
EENT (EAR, EYES, NOSE, THROAT)	YES	NO	YES	NO	
ENDOCRINE DISORDERS	YES	NO	YES	NO	
GALLBLADDER DISEASE	YES	NO	YES	NO	
GENETIC DISEASE	YES	NO	YES	NO	
HEART DISEASE	YES	NO	YES	NO	
HEMOGLOBINOPATHY	YES	NO	YES	NO	
HEPATITIS	YES	NO	YES	NO	
HIGH CHOLESTEROL	YES	NO	YES	NO	
INFERTILITY	YES	NO	YES	NO	
IMMUNE SYSTEM DISORDERS	YES	NO	YES	NO	
INTESTINAL DISORDERS	YES	NO	YES	NO	
KIDNEY DISORDERS	YES	NO	YES	NO	
LIVER DISEASE	YES	NO	YES	NO	
LUNG DISEASE	YES	NO	YES	NO	
MULTIPLE BIRTHS	YES	NO	YES	NO	
NEUROLOGIC DISORDERS	YES	NO	YES	NO	
ORTHOPEDIC	YES	NO	YES	NO	
PULMONARY EMBOLISM	YES	NO	YES	NO	
DEEP VEIN THROMBOSIS	YES	NO	YES	NO	
PSYCHIATRIC DISORDERS	YES	NO	YES	NO	
STROKES	YES	NO	YES	NO	
TUBERCULOSIS	YES	NO	YES	NO	
OTHER	YES	NO	YES	NO	

Patient Signature: ____ Date: ______________

Physician Signature: ____ Date: ______________