 Patients Name:_____

DR. GLENA J. DAVIS
OBSTETRICS/GYNECOLOGY
PATIENT MEDICAL HISTORY FORM

Name_____ Date of Birth_____

Medical History

Have you ever had any of the following?

- ❑ Anemia
- ❑ Heart Disease/Attack
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Bleeding Problems
- ❑ Blood Clots in Lungs/Legs
- ❑ Gall Bladder Disease
- ❑ Liver Disease/Hepatitis
- ❑ Kidney Infections
- ❑ Bladder Infections
- ❑ Pelvic Infections
- ❑ Arthritis
- ❑ Chicken Pox
- ❑ Epilepsy/Seizures
- ❑ Migraines
- ❑ Depression/Anxiety
- ❑ Drug or Alcohol Problem
- ❑ Diabetes
- ❑ Asthma
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Sickle Cell Disease
- ❑ Thyroid Problem
- ❑ Blood Transfusion
- ❑ Genetic Condition
- ❑ Cancer

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

List any allergies to medications: _____❑ No Known Allergies

Surgical History

Please list all surgeries with dates:

Obstetrical History

❑Check here if you have never been pregnant

❑Check here if you have adopted children and list names below.

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:
Type of ;Length of; Year; M/F; Weight; Delivery; Pregnancy ProblemsName/Age
(e.g., preterm labor,
Diabetes, high blood
Pressure)

 Patients Name:_____

Gyn History

Age of first period _____ Date of Last Menstrual Period_____

Cycle length: every _____ days
lasting _____ days

Periods are:

❑ Regular❑ Irregular❑ Painful ❑ Not really bothersome

Flow is:

❑ Light❑ Light to moderate❑ Moderate to heavy ❑ Very heavy

Are you sexually active?

❑ Yes ❑ No ❑ virginal

New partners? ❑yes ❑no

Number of lifetime partners _____

Method of Birth Control:

❑ condoms
❑ pills
❑ patch
❑ vaginal ring
❑ tubal/Essure
❑ IUD
❑ partner with vasectomy
❑ natural family planning
❑ other
❑ none

Have you ever had any of the following STDs?

❑ Chlamydia
❑ Gonorrhea
❑ Herpes
❑ HPV
❑ Syphilis
❑ Trichomonas
❑ HIV
❑ Hepatitis B
❑ Hepatitis C
❑ Never had any

Have you ever had any of the following?

❑ Fibrocystic Breasts ❑Ovarian Cysts ❑Endometriosis ❑Uterine Fibroids

Date of last pap smear_____❑ Normal ❑Abnormal

Have you ever needed any of the following for an abnormal pap?

Date of last mammogram _____

Date of last bone density _____

❑ Normal
❑ Abnormal
❑ Osteopenia
❑ Never had one
❑ Osteoporosis

Date of last colonoscopy_____ or ❑Never had one

 Patients Name:_____

Review of Systems

1. **Constitutional** ❑Negative ❑Weight Gain ❑Weight Loss ❑Fever ❑Fatigue ❑Other
2. **Eyes** ❑Negative ❑Vision Change ❑Glasses/Contacts ❑Other
3. **Ears, Nose & Throat** ❑Negative ❑Ulcers ❑Sinuses ❑Headache ❑Hearing Loss ❑Other
4. **Cardiovascular** ❑Negative ❑Chest Pain ❑Difficulty Breathing ❑Edema ❑Palpitations ❑Other
5. **Respiratory** ❑Negative ❑Wheezing ❑Shortness of Breath ❑Cough ❑Other
6. **Gastrointestinal** ❑Negative ❑Diarrhea ❑Bloody Stool ❑Nausea/Vomiting ❑Flatulence ❑Pain ❑Constipation ❑Fecal Incontinence ❑Other
7. **Genitourinary** ❑Negative ❑Abdominal Pain/Swelling ❑Blood in Urine ❑Difficulty Urinating ❑Frequent Urination ❑Pain in Lower Back ❑Painful Urination ❑Excessive Bleeding ❑No periods ❑Lack of Sex Drive ❑Other
8. **Musculoskeletal** ❑Negative ❑Muscle Weakness ❑Muscle or Joint Pain ❑Other
9. **Skin** ❑Negative ❑Rash ❑Ulcers ❑Pigmented Lesions ❑Dry Skin ❑Other
10. **Breasts** ❑Negative ❑Lump(s) ❑Pain ❑Discharge from nipple (s) ❑Other
11. **Neurological** ❑Negative ❑Dizziness/Fainting ❑Headaches ❑Memory Loss ❑Tingling/Numbness ❑Difficulty Walking ❑Other
12. **Psychiatric** ❑Negative ❑Depression ❑Anxiety ❑Crying ❑Other
13. **Endocrine** ❑Negative ❑Diabetes ❑Thyroid❑Hair Loss ❑Heat/Cold Intolerance ❑Other

It is Dr. Davis' goal to provide the best possible treatment to all of her patients. It is important that you fully disclose all requested information to ensure you have not only the proper treatment to the best possible treatment. By signing below you affirm that you have disclosed all requested medical information to the best of your recollection and that you hold harmless Dr. Glena Davis and her employees harmless for any errors or omissions to the requested information.

Patient Signature_____ Date_____