OB-GYN CENTER
NEW PATIENT/PREOP INFO SHEET

Name ________________________________ Marital status ______ D. O. B. ________ Age ____ Date ________

Occupation ____________________ Pharmacy _________________ Family MD/Referral _________________

Chief Complaint ____

History of Present Illness (Location, duration, quantity, severity, aggravating/alleviating factors, etc.)

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Menstrual/Reproductive History

Last Period ________ ☐ normal How often? ______ How long? _____ Pain ______ Amount______ Age of onset _____

Pregnancies

Total ____ Term ____ Premature ____ Stillbirth ____ Miscarriage ____ Abortion ____ Ectopic _____ Living _____

Birth Control/Hormone therapy _____________________ **Allergies/Drugs** ______________________

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Health Maintenance: **Last Mammogram** _________________

Last Colonoscopy _________________

Last Pap Smear ___________________ Results ___________ HPV vaccine: Yes No

Abnormal Pap History and Treatment ____

PAST MEDICAL HISTORY/FAMILY HISTORY/REVIEW OF SYSTEMS

Symptom/Dz	√	Family Hx	Details:	Symptom/Dz	√	Family Hx	Details
Weight loss/gain				Skin disorders			
Fever				Breast problems			
Eyes, ears, nose				Neurological			
Throat, neck				Psych, mood			
Cardiac/hypertension				Depression			
mitral valve prolapse				Endocrine/diabetes			
murmur				Blood disorders			
Respiratory/asthma				Blood transfusions			
GI, nausea, vomiting				Cancer			
Bowel changes				**Present or history of**		Amount/Day	
Bladder, kidney				Tobacco use			
Musculoskeletal				Alcohol use			
Other				Street Drugs(last use)			

PREVIOUS SURGERIES/HOSPITALIZATIONS

Month	Year	Hospital	Reason (type of surgery, infection, illnesses, etc.)

PAST PREGNANCIES (Last 4)

Date	GA weeks	Weight	Vag/C-S	Anesthesia	Hospital	Stillbirth	Preterm labor	Complications

MEDICATIONS (include medications taken within last 6 months)

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