SUNFLOWER OB-GYN, PA

Name:_____Date:_____

Thank you for choosing Sunflower Ob-Gyn, PA as your health care provider today. To better serve you and provide you with quality care, we ask that you complete the following checklist. If you check "YES" on any item, please discuss it with the doctor as it may affect your method of care or treatment. It is not our intention to offend any person by the content of these questions. Rather, it is our intention to provide comprehensive quality care to all our patients. You may choose to leave any question unanswered, but realize this may affect the quality of care rendered. Please feel free to discuss any concerns with the nurse or the doctor while you are here.

In the past at any time, have you ever had, or do you have now:	**NO**	**YES**	Date of diagnosis:	Date of treatment:
Changes in Moles/Skin lumps				
Skin Cancer				
Cardiac Disease				
Other Cancers--please specify				
Tuberculosis				
Hepatitis or Yellow Jaundice				
Diabetes				
Asthma				
Lung problems--please specify				
Have you ever had a blood transfusion?				
Thyroid problems				
Epilepsy				
Heart Problems				
Mental Illness				
Physical Disabilities				
Blood Disease (sickle cell, clots, etc..)				
Hypertension (high blood pressure)				
Kidney Disease				
Breast Lumps or Breast Cancer				
Abnormal Pap Smears				
History of Sexually transmitted Diseases (STD), Including: Gonorrhea, Chlamydia Herpes, Syphilis, HIV, AIDS, etc...				
Have you had more than two sexual partners in your lifetime?				
Who is your Family Physician or Primary Care Provider?				
Are you allergic to any medications? If so, which medications--				
Are you allergic to Latex?				

Which pharmacy do you use?_____

Are you presently taking any medications (prescription or over the counter)?

NO☐ **YES**☐ *If so, please list:*_____

_____

_____

Please list any **stays in the hospital** or **surgeries** that you have had, along with the year that they happened:_____
_____
_____

When was the first day of your last period?			
How old were you when your periods started?		Are your periods regular?	
How many times have you been pregnant?		How many living children do you have?	

What form of birth control (if any) are you currently using?

Please specify the number of each of the following that you have had:	#		#
Vaginal Deliveries:		Premature Babies (born before 36 weeks):	
Tubal (ectopic) pregnancies:		Miscarriages:	
Cesarean Sections:		Elective Abortions:	

Has anyone in your family been diagnosed with or have a history of:	NO	YES	*Their relationship to you?* ***Please specify Maternal of Paternal side of your family:***
Breast Cancer			
Ovarian Cancer			
Uterine Cancer			
Colon Cancer			
Diabetes			
Hypertension (High Blood Pressure)			
High Cholesterol			
Heart Disease			
Any other Cancers? *Please specify which type!*			

Do you use tobacco in any form? NO ☐ YES ☐
If so, for how many years? _____How much per day?_____
Do you drink alcohol? NO ☐ YES ☐
If so, how often?_____ How much?_____

Have you at any time in the past or present been addicted to drugs? (Street or prescription)
NO ☐ YES ☐ What kind?_____
Are you currently using, or have you in the past year used illegal drugs of any kind?_____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐
What is your occupation?_____

Do you have any special concerns today?_____
_____
_____