TEXAS OB·GYN

Caring For Generations Of Texas Women

Please Complete the Following Information (please print clearly)

First Name ______ Middle Initial ______ Last Name ______ Age ______ Date of Birth ______

Address ______ City ______ State ______ Zip Code ______

Cell Phone ______ Work Phone ______ Home Phone ______

Emergency Contact/Spouse's Name ______ Cell Phone ______ Work Phone ______

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

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Allergies: (list all allergies)

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Gynecologic History

Last menstrual period: ______________________

How many days do you bleed?________________
❑ Light ❑ Normal ❑ Heavy

History of sexually transmitted infections or PID?

❑Chlamydia ❑Gonorrhea ❑Trichomonas ❑ Herpes

Date of Last Pap: __________________________

Abnormal Pap? What Treatment and When?

Current Birth Control Used: __________________

Social History:

Tobacco Use:

- ❑ Never
- ❑ Quit, how long not smoking? ____________
- ❑ Yes, how long? ____ ____ packs/week

Alcohol Use:

- ❑ Never
- ❑ Yes. How often? ______________________

Illicit drug use:

- ❑ Never
- ❑ Yes, List: ___________________________

How did you hear about us:

Past Medical History (Please check any past/current conditions.)

- ❑ Gynecology Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Pneumonia
- ❑ Thyroid Problems
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Sexual or Physical Abuse
- ❑ Decreased Sex Drive
- ❑ Relationship Issues
- ❑ Anxiety/Depression/Mood Swings
- ❑ Urinary Problems – leaking, urgency, need pad
- ❑ Others

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Obstetrical History

Please list all pregnancies below:

Year	M/F	Type of Delivery	Wt	Comps

Family Medical History

Father ❑ Alive ❑ Deceased at age _____
Mother ❑ Alive ❑ Deceased at age _____

Any Family Health Issues?

		Relationship to you
Breast Cancer………...	❑	_______________
Gynecology Cancers	❑	_______________
Diabetes........................	❑	_______________
Heart Disease	❑	_______________
High Blood Pressure	❑	_______________
Migraines	❑	_______________
Colon Cancer	❑	_______________

Referring Physician/Other Physicians:

____

Routine Medications:

List all medications & dosages you are currently taking including over the counter and herbals:

____
____
____
____
____

Past Surgeries:

Please list all surgeries you have had in the past with year of surgery.

____
____
____
____
____

Problem List:

List all ongoing medical problems:

____
____
____
____
____
____

Preferred Pharmacy:

Name: _____________________________________

Location: __________________________________

Phone: ____________________________________

Fax: ______________________________________

____
Patient Signature

____
Date