

GLENS FALLS OBSTETRICS & GYNECOLOGY CENTER, PC

**28 So. Western Ave.
Queensbury, NY 12804**

**Douglas Provost, MD
Michael Guido, MD**

Sereena Coombes, MD

**Carrie Mylott, CNM
Marybeth Manrique, CNM**

MEDICAL HISTORY SHEET

Patient Name _____ DOB _____ Date _____

Chief Complaint: _____

List all medication allergies & adverse reaction: _____

List all current medications you are taking with dosage amt: _____

List any **Past Medical history (include accidents, surgery, childhood diseases) include date:** _____

List any **Family Medical History (Check and explain relation)**

Osteoporosis	No	Yes	_____	Cancer-breast	No	Yes	_____
Stroke Disease	No	Yes	_____	-uterus	No	Yes	_____
Heart Disease	No	Yes	_____	-ovary	No	Yes	_____
Diabetes	No	Yes	_____	-cervix	No	Yes	_____
Other _____				-colon	No	Yes	_____

List any **Social History**

Do you or did you smoke? Yes No How much? _____ If quit, when? _____
Do you or did you drink alcohol? Yes No How much? _____ If quit, when? _____
Do you drink coffee/caffeine? Yes No How much? _____
Do you regularly exercise? Yes No How often? _____
Do you use street drugs? Yes No How often? _____

Review of Your Body Systems: Do you have or have you ever had any of the following? Please Circle Yes/No explain

Head, Headaches	No	Yes	_____
Breast Disease	No	Yes	_____
Ear, Nose, Throat	No	Yes	_____
Thyroid Disease	No	Yes	_____
Heart Disease, Chest Pain	No	Yes	_____
Shortness of breath	No	Yes	_____
Lung Disease, Asthma	No	Yes	_____
Emphysema	No	Yes	_____
Gall Bladder Disease	No	Yes	_____
Kidney Disease	No	Yes	_____
Bones, Joints, arthritic	No	Yes	_____
Cancer (location)	No	Yes	_____
Diabetes	No	Yes	_____
Hypertension (high blood pres)	No	Yes	_____
Depression, Anxiety	No	Yes	_____
Ulcers	No	Yes	_____
Jaundice/Hepatitis	No	Yes	_____
Urinary Tract Problems	No	Yes	_____
Varicose Veins/Phlebitis	No	Yes	_____
Blood Disease/Anemia	No	Yes	_____
Epilepsy/Seizures	No	Yes	_____

Patient Name _____ **GLENS FALLS OBSTETRICS & GYNECOLOGY CENTER**

Menstrual History:

Date of last period? _____ Normal Length of period? _____ Cycle(every 28,30,35 days etc) _____
Age of first period? _____ Date of last pap smear? _____ Amt. Per heaviest day (# of pads) _____
Abnormal Bleeding _____ Pain (describe) _____ Vaginal discharge _____

Sexual History:

Sexually Active _____ Yes _____ No _____

Marital History:

_____ M _____ S _____ D _____ W

Family Planning:

Pregnancies: No. of children _____ No. of Pregnancies _____ Planning Pregnancy? _____

Pregnant? _____ How many weeks? _____ Miscarriages? _____ Abortions? _____ Premature Births? _____

Sterilization: _____ Male _____ Female ; Infertility: _____ Yes _____ No; Duration _____

Contraceptive: Oral _____ (describe) _____ IUD _____ Diaphragm _____ Other _____

Last Breast Exam? _____ **Where?** _____ **Last Mammogram** _____ **Where?** _____

No. Born (mo/yr)	Wt. At Birth	Sex	Wks Preg.	Type of Delivery	Complications (describe)
1	lbs. oz.				
2	lbs. oz.				
3	lbs. oz.				
4	lbs. oz.				
5	lbs. oz.				

Describe any Ob/Gyn problems that you may or may have had? _____

There are very specific parameters that could put you at high risk for cervical cancer. Please answer the following:

Onset of sexual activity under 16 years of age? _____ No _____ Yes
Five or more sexual partners in a lifetime? _____ No _____ Yes
History of sexually transmitted disease? _____ No _____ Yes
Absence of three negative Pap smears? _____ No _____ Yes
History of HIV? _____ No _____ Yes
Absence of any Pap smears within the previous seven years? _____ No _____ Yes
Prenatal exposure to DES? _____ No _____ Yes

Tests and Immunizations (Please give the date these were last done)

	Yes	Year Performed	Never	Comments
Pneumonia Vaccine	_____	_____	_____	_____
Tetanus Shot	_____	_____	_____	_____
Flu Shot	_____	_____	_____	_____
Rubella	_____	_____	_____	_____

Any other medical history we should be aware of? _____

Notes;

Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____