ADVANCED OB/GYN SLO CITY MIDWIVES

Patrick J. Spalding, MD

PATIENT HISTORY

NAME_____**AGE**_____ **MARITAL STATUS**_____

ETHNIC BACKGROUND_____

MEDICAL HISTORY

	YES /NO		YES /NO
HIGH BLOOD PRESSURE	___ ___	BREAST LUMP	___ ___
HEART DISEASE/PROBLEMS	___ ___	ANEMIA	___ ___
STROKE	___ ___	VAGINAL INFECTION	___ ___
DIABETES	___ ___	INFECTION OF UTERUS/TUBES	___ ___
MIGRAINES	___ ___	URINARY TRACT DISEASE	___ ___
FREQUENT HEADACHES	___ ___	DES EXPOSURE	___ ___
THYROID DISEASE	___ ___	UTERINE ABNORMALITIES	___ ___
LIVER DISEASE	___ ___	ANY TYPE OF CANCER	___ ___
MONONUCLEOSIS	___ ___	CLOTS IN LEGS OR LUNGS	___ ___
(within 6 months)	___ ___	PHELBITIS(inflammation of veins)	___ ___
BLADDER INFECTION	___ ___	VARICOSE VEINS	___ ___
KIDNEY DISEASE	___ ___	RHEUMATIC FEVER	___ ___
EPILEPSY (SEIZURES)	___ ___	EYE PROBLEMS	___ ___
TUBERCULOSIS	___ ___	OSTEOPOROSIS	___ ___
SYPHILIS, GONORRHEA, HERPES,		LUNG DISEASE	___ ___
CHLAMYDIA, or GENITAL WARTS	___ ___	GALL BLADDER DISEASE	___ ___
ALLERGIES	___ ___	USE OF NARCOTICS	___ ___
MENTAL/EMOTIONAL DISORDER	___ ___	USE OF OTHER STREET DRUGS	___ ___

OTHER_____

PREVIOUS HOSPITALIZATION/SURGERY (GIVE DATES AND REASONS):

_____

ABNORMAL PAP SMEAR: YES____ NO____ REASON: _____
DATE OF LAST PAP SMEAR: _____
ABNORMAL MAMMOGRAM: YES____ NO____ REASON: _____
DATE OF LAST MAMMOGRAM: _____

FAMILY HISTORY

OSTEOPOROSIS ____ CANCER ____ CARDIOVASCULAR ____ HYPERTENSION ____
DIABETES ____ CEREBROVASCULAR (STROKE) ____ OTHER_____

PERSONAL HISTORY

CURRENT MEDICATIONS

_____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? (IF SO, PLEASE LIST THEM)

_____

DO YOU SMOKE? YES____ NO____ IF YES, HOW MUCH? _____
HOW OFTEN? _____ FOR HOW LONG? _____
DO YOU DRINK ALCOHOL? YES____ NO_____ IF YES HOW MUCH?_____
HOW OFTEN? _____ FOR HOW LONG? _____
CAFFEINE? YES____ NO____ IF YES, HOW MUCH? _____
EXERCISE? YES____ NO____ IF YES, HOW MUCH? _____

MENSTRUAL HISTORY

AGE STARTED _____DAYS OF FLOW _____ AMOUNT: LIGHT_____ MEDIUM_____ HEAVY_____
NUMBER OF DAYS FROM DAY ONE OF PERIOD TO FIRST DAY OF NEXT PERIOD _____
ARE YOUR CYCLES: REGULAR_____ IRREGULAR_____
ARE YOU HAVING ANY PROBLEMS? _____
IF POST-MENOPAUSAL, WHAT AGE DID IT START MENOPAUSE? _____

PREGNANCY HISTORY

PREGNANCIES _____ # LIVE BIRTHS _____ # PREMATURE BIRTHS_____
MISCARRIAGES _____ # ABORTIONS _____ # STILL BIRTHS _____
INFANT DEATHS _____ # LIVING CHILDREN _____ # ECTOPIC (TUBAL) _____
VAGINAL DELIVERIES _____ # CESAREAN SECTIONS _____
HAVE YOU HAD ANY COMPLICATIONS WITH PREGNANCY/ CHILDBIRTH/ ABORTION/ MISCARRIAGE?

CONTRACEPTIVE HISTORY

CURRENT CONTRACEPTIVEMETHOD

_____

PREVIOUS METHODS USED

_____