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	LIMD	
LIEADT DIOCAGE/DDODI EMO	ANEMIA	LOWII	
OTDOVE		INFECTION	
STROKE	_	. INFECTION	
DIABETES		ON OF UTERUS/TUBES	
MIGRAINES	URINARY	/ TRACT DISEASE	
FREQUENT HEADACHES	DES EXP	OSURE	
THYROID DISEASE	UTERINE	ABNORMALITIES	
LIVER DISEASE	ANY TYP	E OF CANCER	
MONONILIOLEGGIO	CLOTS IN	N LEGS OR LUNGS	
(within 6 months)		IS(inflammation of veins)	
,		SE VEINS	
KIDNEY DISEASE		TIC FEVER	
EPILEPSY (SEIZURES)	EYE PRO		
TUBERCULOSIS	OSTEOP		
SYPHILIS, GONORRHEA, HERPES,	LUNG DI	SEASE	
CHLAMYDIA, or GENITAL WARTS	GALL BL	ADDER DISEASE	
ALLERGIES	USE OF I	NARCOTICS	
MENTAL/EMOTIONAL DISORDER		OTHER STREET DRUGS	
OTHER	002 01	omen omeer brood	
OTTEN			
PREVIOUS HOSPITALIZATION/SURGERY (GIVE DA	ATES AND REA	ASONS):	
ABNORMAL PAP SMEAR: YES NO	_ REASON:		
DATE OF LAST PAP SMEAR:			
ABNORMAL MAMMOGRAM: YES NO	_ REASON:		
DATE OF LAST MAMMOGRAM:			
FAMILY HISTORY			
OSTEOPOROSIS CANCER	CARDIOVA	ASCULAR HYPERTEN	SION
DIABETES CEREBROVASCULAR (STROKE) _	CARDIOV/ OTHER	ASCULAR HYPERTEN	SION
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY	CARDIOV/ OTHER	ASCULAR HYPERTEN:	SION
DIABETES CEREBROVASCULAR (STROKE) _	CARDIOV/ OTHER	ASCULAR HYPERTEN: 	SION
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY	CARDIOVA OTHER	ASCULAR HYPERTEN:	SION
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY CURRENT MEDICATIONS	OTHER		SION
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY	OTHER	, PLEASE LIST THEM)	
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY CURRENT MEDICATIONS DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS	OTHER	, PLEASE LIST THEM)	
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DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY CURRENT MEDICATIONS DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS DO YOU SMOKE? YES NO IF YES, HOW OFTEN? FOR HOW LONG?	OTHER TIONS? (IF SO	, PLEASE LIST THEM)	
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY CURRENT MEDICATIONS DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS DO YOU SMOKE? YES NO IF YES, HOW OFTEN? FOR HOW LONG? DO YOU DRINK ALCOHOL? YES NO IF	OTHER TIONS? (IF SO OW MUCH? YES HOW MU	, PLEASE LIST THEM)	
DO YOU SMOKE? YES FOR HOW OFTEN? DO YOU DRINK ALCOHOL? YES NO IF YES, HOW OFTEN? FOR HOW OFTEN? DO YOU DRINK ALCOHOL? YES NO IF FOR HOW OFTEN?	TIONS? (IF SO OW MUCH? YES HOW MUCOW LONG?	, PLEASE LIST THEM)	
DO YOU SMOKE? YES NO IF YES, HOW OFTEN? FOR HOW OFTEN	TIONS? (IF SO OW MUCH? YES HOW MUCOW LONG? CH?	, PLEASE LIST THEM)	
DO YOU SMOKE? YESNO IF YES, HOW OFTEN? FOR HOW OFTEN? FOR HOW CAFFEINE? YES NO IF YES, HOW OFTEN? FOR HOW OFTEN? FOR HOW LONG? IF YES, HOW OFTEN? FOR HOW LONG? IF YES, HOW OFTEN? FOR HOW OFTEN? FOR HOW OFTEN? FOR HOW OFTEN? FOR HOW OFTEN? YES NO IF YES, HOW MUCEXERCISE?	TIONS? (IF SO OW MUCH? YES HOW MUCOW LONG? CH?	, PLEASE LIST THEM)	
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DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY CURRENT MEDICATIONS	OTHER	, PLEASE LIST THEM) CH? LIGHT MEDIUM OF NEXT PERIOD ? # PREMATURE BIRTHS # STILL BIRTHS	HEAVY
DIABETES CEREBROVASCULAR (STROKE) _ PERSONAL HISTORY CURRENT MEDICATIONS DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS DO YOU SMOKE? YES NO IF YES, HOW OFTEN? FOR HOW LONG? DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MUCHARD FOR HOW OFTEN? FOR HOW OFTEN? FOR HOW SEXERCISE? YES NO IF YES, HOW MUCHARD MENSTRUAL HISTORY AGE STARTED DAYS OF FLOW NUMBER OF DAYS FROM DAY ONE OF PERIOD TO ARE YOUR CYCLES: REGULAR IF POST-MENOPAUSAL, WHAT AGE DID IT START PREGNANCY HISTORY # PREGNANCIES # LIVE BIRTHS # MISCARRIAGES # ABORTIONS # MINFANT DEATHS # LIVING CHILDRE	OTHER	# PREMATURE BIRTHS # STILL BIRTHS # ECTOPIC (TUBAL)	HEAVY
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