Hera Ob/Gyn Medical Group, Inc.

Patient Information Form

Name____ Birthdate__________________________

Primary Care Physician__________________________ Pharmacy__________________________

REASON FOR TODAY'S VISIT:____
____

ALLERGIES(including medications and over-the-counter products):

_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

MEDICATIONS INCLUDING DOSAGE AND DIRECTIONS:
(prescriptions, vitamins, herbs & over-the-counter medication you take regularly)

_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

SURGICAL HISTORY: _Year_ _Type of Surgery__________________________________

______ ____
______ ____
______ ____
______ ____

CURRENT MEDICAL CONDITIONS:

_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

PAST MEDICAL CONDITIONS:

_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

REPRODUCTIVE HISTORY:
How many times have you been pregnant?_____
Deliveries?_____Miscarriage?_____Abortion?_____Ectopic?_____Stillbirth?_____Living?_____
What do you currently use for contraception?____
Last menstrual period?____________Post-Menopausal?__________Hysterectomy?______
Have you ever had an abnormal pap smear? _____If yes, when?_____Treatment, if any?_____

SOCIAL HISTORY:

Occupation: ____

Tobacco(circle one) None/_____packs per day/Quit How long ago?____________

Alcohol(circle one) None/Social/Other___________________________________

Illicit Drug Use No/Yes If yes…Type?____________How Often?____________

Marital Status(circle one) Single/Married/Separated/Divorced/Widowed/Same Sex Parter

Sexually Active (circle one) Yes/No/Never

FAMILY MEDICAL HISTORY:

Mother:____

____

Father:____

____

Siblings:____

____

2nd Degree Relatives:____

____

Signature_______________________________________Date___________________________