OMNI Medical Center for Women omc4women.com

Patient Medical History Form

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize that this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you . Name

Patient Name: ____ **Date of Birth:** ______________________

Primary Care Physician: ____ **Phone:** ______________________

Pharmacy Name: ____ **Phone:** ______________________

What is the reason for your visit: _____ New Patient Visit _____ Initial Pregnancy Visit

If you are here for a problem, what are your concerns? ____

____

Personal Medical History: Check if you had any of these medical problems in the past.

Major Illness	Yes	Major Illness	Yes
Anemia		Hepatitis □A □B □C	
Anxiety		High Blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- List Type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type 1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis (TB)	

Past Surgical History: □ **No past surgical history**

Year	Surgery	Complications

Allergies: (Food, Drugs, Environmental) _____None _____ Latex _____Iodine

Allergy	Interaction

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Current Medications: _____ None If there is not sufficient space please attach copy of medications list to this form.
Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Pap smears History:

Pap smear	□ Yes □ No	If yes, date ____/____/____	Results:	□ Normal	□ Abnormal
LEEP	□ Yes □ No	If yes, date ____/____/____	Results:	□ Normal	□ Abnormal
Colposcopy	□ Yes □ No	If yes, date ____/____/____	Results:	□ Normal	□ Abnormal
History of HPV?	□ Yes □ No	If yes, date ____/____/____			
Received HPV vaccine?	□ Yes □ No	If yes, date ____/____/____	□ Inj. 1	□ Inj. 2	□ Inj. 3

Genetic Screening: _____ None Includes patient, baby's father, or anyone in either family

Indicate Yes or No	Yes	No	Indicate Yes or No	Yes	No
Neural Tube Defect			Maternal Metabolic Disorder		
Tay-Sachs			Mental Retardation/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart Defect		
Sickle Cell Disease or Trait			Recurrent pregnancy loss or a still birth		
Patient or father of the baby had/has a child with birth defects not listed			Other Inherited Genetic or Chromosomal Disorder		

Health Maintenance Screening Tests:

Mammogram	□ Yes □ No	If yes, date ____/____/____	Results:	□ Normal	□ Abnormal
Dexa Scan	□ Yes □ No	If yes, date ____/____/____	Results:	□ Normal	□ Abnormal
Colonoscopy	□ Yes □ No	If yes, date ____/____/____	Results:	□ Normal	□ Abnormal

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Gynecology:

Age at first period:	1st day (date) of last period:
Frequency of period:	Describe Period: ☐ Light ☐ Normal ☐ Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? ☐ Yes ☐ No Date of last period: Are you on hormone replacement therapy? ☐ Yes ☐ No

Obstetrics:

	Number		Number
Total number of pregnancies		Abortions Elective	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	#weeks at delivery	Sex	Birth Weight	Delivery Type	Complications
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

Social History

Have you traveled outside of the US within the last six months? ____Yes _____No, If Yes, Where ____________________________

Are you currently sexually active? _____ Yes _____ No If yes, what age did you become sexually active? _______

Current sexual partner(s) is/are: _____ Male _____ Female Male and Female_______

Have you had more than 5 sexual partners in a lifetime? _____ Yes _____ No If yes, how many? __________

Have you ever has any sexually transmitted disease? (STDs): _____ Yes _____ No If yes, what kind? ________________________________

Are you interested in STD screening? _____Yes _____No

Do you drink alcohol? _____ Yes _____ No If yes, how many drinks per day? ______ per week? _______ Or socially _______

Do you use recreational drugs? _____ Yes _____ No If yes, what kind? ____

Do you currently use tobacco? _____ Yes _____ No If yes, how many cigarettes per day _______

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Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: ☐ No Family History ☐ Adopted

	None	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Blood Clots/DVT									
Breast Cancer									
Cervical Cancer									
Ovarian Cancer									
Uterine Cancer									
Colon Cancer									
Diabetes									
Hypertension									
Stroke									
Other Cancers not mentioned									
Other disease's not mentioned									

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care an d treatment as self-referred or as ordered by my physician, his/her assistant or designees.

____ Patient Signature

____ Date

Please mail or fax (813)283-6700 your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, **you must arrive 30 minutes early** so we can enter your information into the computer. This information needs to be entered prior to you seeing a provider

Thank you for your attention and cooperation.

The Staff at OMNI Medical Center for Women