N9NE OB GYN MEDICAL HISTORY FORM

NAME:_____ BIRTH DATE:____/____/_____ DATE:____/____/____

ADDRESS:_____ NATIONALITY:_____

MOBILE NO. _____ E:MAIL:_____

REFFERED:_____ INSURANCE:_____

PERSONAL PROFILE

Marital Status Married ☐ Single ☐

Number of Living Children_____

Number of people in household_____

Occupation: _____

SOCIAL HISTORY

Smoking: _____ Alcohol: _____

Husband's Information:

Name of Spouse: _____ Age: _____ Date of Birth: _____

Nationality: _____ Occupation: _____

Significant Medical History: _____

OBSTETRICAL HISTORY

Number of Pregnancy: _____ Number of Delivery: _____

Details of Delivery:

Year	Gender	Weight	Mode of Delivery	Complications / Comments	Now

GYNECOLOGICAL HISTORY

Menarche: _____ LMP: _____

Cycle Lengh: _____ Bleeding Duration: _____

Contraception: _____ Sonomammogram (if available): _____

History of STDs (if any):

	Year	Results / Comments
Latest Pap smear (History of Abnormal Pap smear)		
Past gynecological disorder		
Past gynecological surgery		
Past Surgical History		

FAMILY HISTORY

Has anyone in the family had:	No	Yes	Details if Yes
Diabetes			
Blood disorders / Thrombosis (Blood clots)			
High blood pressure			
Thyroid problem			
Renal problem			
Gynecological cancer (breast / cervix)			
Genetic / Chromosomal / congenital abnormalities (down syndrome, heart defects)			

MEDICAL HISTORY			
Do you have / have you had any of the following:	No	Yes	If Yes, please provide details
Anaesthetic Problem			
Allergies (including Latex)			
Asthma or Chest problem			
Back Problem			
Blood disorder			
Blood transfussion			
Cancer			
Diabetes			
Epilepsy / Neurological problems			
Exposure to toxic chemicals			
Gastrointestinal problems (eg. Crohns)			
Genital Infection (eg. Chlamydia /herpes)			
Heart Problem			
High Blood Pressure			
Infection (eg. MRSA, GBS)			
Kidney / Urinary problems			

Liver disease including hepatitis			
Migraine or Severe headaches			
Musculoskeletal problems			
Pregnancy problems (PET, preterm labor			
Sickle Cell / Thalassemia			
TB exposure			
Thrombosis			
Thyroid problem			
Medications in the last 6 months			
Vaginal bleeding			
Others			

Please bring all your relevant documents (ultrasound reports, laboratory, imaging results) on the day of your appointment

_____ _____

Patient Signature Print Name

_____

Date