Memorial Hermann Medical Group
New Patient Medical History Form - Obstetrics and Gynecology

Last Name:	**First Name:**
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female**
Preferred Phone: ☐ **Home** ☐ **Work** ☐ **Cell**	**Alternate Phone:** ☐ **Home** ☐ **Work** ☐ **Cell**
Reason for todays visit:	

Patient and Family Medical History:

Condition	Patient	Mother	Father	Sibling	Grandparent
Allergies					
Abnormal Pap Smear					
Anemia					
Anesthetic Complications					
Anxiety/Depression					
Asthma/Reactive Airway Disease					
Autoimmune disorder					
Blood Clots					
Blood Transfusion					
Breast Disorder					
Cancer					
Cats at Home					
Chicken Pox					
Diabetes					
Emphysema					
Gout					
Heart Attack					
Heart Failure					
High Blood Pressure					
High Cholesterol					
HIV					
Illicit Drugs					
Infertility					
Kidney Disease					
Liver Disease					
Lupus					
Lymphoma/Leukemia					
Migraines					
Neurological Disorder					
Psychiatric Disorder					
Renal Disease					
(Rh) Sensitized					
Osteoporosis					

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Patient Name:	DOB:

Condition	Patient	Mother	Father	Sibling	Grandparent
Reflux/Ulcers					
Seizures					
Stroke					
Suicide					
Tattoos (if yes, how many?)					
Thyroid Disease					
Trauma History					
Uterine Abnormalities					
Varicosities/ DVT					
Other:					

Surgical History: _____

_____

Hospitalizations: _____

_____

Previous Doctors and Specialists: _____

_____

Life Style:	Yes	No	Past	Frequency	Type
Tobacco					
Alcohol					
Recreational Drugs					
Exercise					

Menstrual History

Date of last menstrual cycle:_____ Cycle Length: _____

Are periods regular? ☐ Yes ☐ No Flow: ☐ Light ☐ Moderate ☐ Heavy How many heavy days? _____

Have your periods changed? ☐ Yes ☐ No

Any pain with periods? ☐ Yes ☐ No Take medications for pain? ☐ Yes ☐ No

If yes, what medications:_____

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Patient Name:	DOB:

Obstetrical History					
	Number		Number		Number
Pregnancies		Live Births		Abortions	
Preterm Births		Miscarriages		Living children	
Father's Name:		Race:		Ethnicity:	

NO.	Delivery Date	# Weeks Pregnant	Type and anesthesia (vaginal, c-section, miscarriage, abortion)	Hours in Labor	Place of birth	Birth weight	Gender	Complications (during pregnancy or delivery)
1								
2								
3								
4								
5								
6								

Genetic & Exposure Screenings					
Are you 35 or older?	☐ Yes ☐ No	Autism	☐ Yes ☐ No	Patient or partner has history of Genital Herpes	☐ Yes ☐ No
Neural Tube defect	☐ Yes ☐ No	Mental Retardation	☐ Yes ☐ No	Exposure to TB	☐ Yes ☐ No
Trisomy 21	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Rash or viral illness since last period	☐ Yes ☐ No
Congenital heart defect	☐ Yes ☐ No	Sickle Cell Disease or trait	☐ Yes ☐ No	History of any Sexually Transmitted Susceptibility	☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No	Inherited Genetic Chromosomal Disorder	☐ Yes ☐ No	Possible Varicella Susceptibility	☐ Yes ☐ No
Tay-Sachs	☐ Yes ☐ No	Maternal Metabolic Disorder	☐ Yes ☐ No	Other exposure or history of infection	☐ Yes ☐ No
Thalassemia	☐ Yes ☐ No	Recurrent pregnancy loss or still birth	☐ Yes ☐ No	Other Genetic Screening	☐ Yes ☐ No
Canavan Syndrome	☐ Yes ☐ No	Huntington's Chorea	☐ Yes ☐ No	Partner with history of HIV	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Other Birth Defects	☐ Yes ☐ No		

Sexual History

Age at first sexual intercourse: _____

Are you currently (within last month) having intercourse: ☐ Yes ☐ No

Have you had greater than 4 lifetime sexual partners? ☐ Yes ☐ No

Have you ever been diagnosed with a sexually transmitted disease (STD)? ☐ Yes ☐ No

Current method of contraception: _____

Have you ever used birth control? ☐ Yes ☐ No If yes, how long? _____

Preventive Care	Date	Result	
Colonoscopy			
Bone Density			
Mammogram			
Pap-smear			
Flu Vaccine			
Pneumonia Vaccine (Over 65)			
Tetanus Booster -- TDaP			
HPV			

Medication Allergies: _____

_____

Any other concerns/problems: _____

_____

Occupation: _____

I have completed the above to the best of my knowledge.

_____ _____

Patient or Parent/Legal Guardian (if patient is considered an incapacitated minor) (signature) **Date**

_____ _____ _____ _____

Witness Signature **Print Name** **Date** **Time**