

Laguna Beach OBGYN, Inc.
Confidential Personal History Information

Date: _____

Name: _____ Age _____ Date of Birth _____

What do you prefer to be called? _____

Are you? () Married () Partnered () Single () Divorced () Widowed () Other

Partner's Name: _____

Reason for your visit? _____

How did you hear about us? _____

What was the first day of your last menstrual period? _____

Are your periods? () Regular () Irregular Age of first menstrual flow? _____

Days between menses _____ Duration of flow _____

Do you have? () Heavy bleeding () Bleeding between periods () Painful periods

What is your method of birth control? _____

Do you experience pain or bleeding during or after intercourse? _____

Last pap smear date? _____ () Normal () Abnormal

Have you ever had an abnormal pap and what was done about it? _____

Date of last mammogram? _____ () Normal () Abnormal

Have you ever had an abnormal mammogram? Explain: _____

Total # of pregnancies _____ # of children _____ # of vaginal deliveries _____
of miscarriages _____ # of c-section deliveries _____
of elective abortions _____ # of ectopic pregnancies _____

Explain if you had complications during pregnancy. _____

Do you smoke? _____ Quantity _____

Do you drink? _____ Quantity _____

Do you use illicit drugs? _____ Kind? _____

Mark below for medical problems.

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|
| () High blood pressure | () High cholesterol | () Endocrine disorder | () Asthma |
| () Heart murmur | () Liver disease | () Epilepsy | () Shortness of breath |
| () Heart disease | () Hepatitis | () Migraine headaches | () Tuberculosis |
| () Diverticular disease | () Urinary infections | () Depression | () Anemia |
| () Hemorrhoids | () Kidney disease | () Psychiatric problems | () Transfusions |
| () Inflammatory Bowel | () Malignancy | () Diabetes | () Blood Disorder |
| () Breast Cancer | () Gynecological Cancer | () Endometriosis | () Colon Cancer |
| () Other _____ | | | |

CONTINUED ON NEXT PAGE

Mark if you have had any of these sexually transmitted diseases.

- Gonorrhea Herpes Genital warts
 Chlamydia Syphilis HIV infection
 Other _____

List any medication that you may be **ALLERGIC** to:

List any medications you are taking (include prescription, non-prescription, vitamins and over-the-counter) _____

Pharmacy Name and Telephone Number: _____

Please list any previous surgeries:

Family History Mark any medical problems in your family.

- Heart High blood pressure Psychiatric Breast cancer
 Kidney Genetic Abnormalities Alzheimer's Gynecological cancer
 Diabetes Tuberculosis Osteoporosis Colon cancer
 Other _____

Mother: Alive Age _____ Medical problems? _____
Dec.age? _____ Cause of death? _____

Father: Alive Age _____ Medical problems? _____
Dec.age? _____ Cause of death? _____

Number of sibling's alive? _____ Medical problems? _____

Number of sibling's dec.? _____ Cause of death? _____

For genetic testing purposes, please mark your ethnic background (Medicare and OB patients must)

- Jewish Ashkenazi Italian Asian
 Jewish Sephardic Black Decline to answer
 Hispanic/Latin White Other _____

Preferred Language _____

The following questions are for "OBSTETRIC" patients only

Have you ever had? Chicken Pox Measles Rubella Rheumatic Fever

Do you have a history of? Incompetent Cervix Pre-term Labor
 Gestational Diabetes Pregnancy Induced

Who is your primary care physician? _____ () _____

Signature: _____ **Date:** _____