Date: ________________

Southern Indiana OBGYN
Medical History

Name: ____ Birthdate: ____________________

Reason for visit: ____

Current and past medical problems or conditions:

__Diabetes __ Hypertension __Thyroid diseases __Depression __Cancer (type_______) ___STD

____

____

____

Date of last flu shot________ Last Menstrual Period: _____________ Last Pap Smear: ____________

Allergies

____

____

FAMILY HISTORY

What medical conditions do your father, mother and siblings have:

____

____

____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how much? ______ Have you smoked in the past? ______

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ____________________________________

Do you use street drugs? ☐ Yes ☐ No If yes, what and how often? ____________________________

Current Medications (including herbal) with dosage information:

____

____

____

OBSTETRICAL HISTORY

Number of Pregnancies _____ Number of vaginal deliveries ______ Number Cesarean deliveries ______

Number of miscarriages _____ Number of Elective Abortions _____

SURGICAL HISTORY

Please list any surgeries, include month and year:

____

____

____

Any other important information you would like to tell us:

____

____

____

If PREGNANT, please complete back side.