LABEL

Moreland OB-GYN Associates, S.C.
1111 Delafield St. Suite 311
Waukesha, WI 53188
(262) 544-4411 • Fax (262) 650-3856

Please complete and return to our office before appointment date, along with all pertinent medical records.

PATIENT HISTORY

Name:	Age:	Date of Birth:	Marital Status:	Previous Name:	Occupation:
Referred by:	Primary MD:		Reason for visit:		

GYN HISTORY

Age at first period:	Last menstrual period (1st day):	# of days between periods:
# of days of flow:	# of pads/tampons per day:	Clots: ☐ Y ☐ N Size:
Cramping: ☐ mild ☐ moderate ☐ severe	Bleeding with intercourse: ☐ Y ☐ N	Pain with intercourse: ☐ Y ☐ N
Bleeding between periods: ☐ Y ☐ N	Vaginal discharge: ☐ Y ☐ N	Itching: ☐ Y ☐ N
Odor: ☐ Y ☐ N	BIrth control used in past:	Current birth control method:
Last pap (date):	Result:	History of abnormal paps: ☐ Y ☐ N When:
Treatment: ☐ Cryo ☐ Laser ☐ Leep ☐ Other		
History of pelvic infections / STD: ☐ Y ☐ N	☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Bacterial Vaginosis	
	☐ Herpes ☐ Trichomoniasis ☐ Syphilis	When last outbreak / treatment:

HEALTH MAINTENANCE

TEST	DATE	RESULT	IMMUNIZATION	DATE	
Last Mammogram			Tetanus		
Bone Density			Influenza		
Cholesterol			Pneumovax		
Thyroid Check			Hep B		
Colonoscopy			TB Test		
			Chicken Pox		
			HPV (Gardasil)		

PERSONAL PAST HISTORY

MAJOR ILLNESS	Y	N		MAJOR ILLNESS	Y	N		MAJOR ILLNESS	Y	N	
Asthma				High Blood Pressure				Anemia/Blood transfusions			CIRCLE ONE
Pneumonia				Stroke				Glaucoma			
Chronic Lung Disease				Rheumatic Fever				Arthritis/joint pain			
Kidney Infection/Stones			CIRCLE ONE	High Cholesterol				Fracture			
Tuberculosis				GI problem				Osteoporosis			
Cancer				Ulcers/GERD			CIRCLE ONE	Hepatitis			
Heart Disease/Murmur			CIRCLE ONE	Seizures				Thyroid Disease			
Diabetes				Depression/anxiety			CIRCLE ONE	Clotting Disorder/Bleeding			CIRCLE ONE
Other				Other				Other			
Other				Other				Other			

SURGERIES

TYPE	DATE	TYPE	DATE

PLEASE COMPLETE REVERSE SIDE

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OB HISTORY

Number of: Pregnancies _____ Miscarriages _____ Abortions _____ Living Children _____

DATE	TYPE OF DELIVERY (Vag / C-section)	SEX	WEIGHT (# / oz)	NAME OF CHILD	PROBLEMS (with pregnancy or delivery)

FAMILY HISTORY

Number of: Sisters _____ Brothers _____ Parents: M - Alive / Deceased F - Alive / Deceased

Family members with the following: include mother (M), father (F), sisters (S), brothers (B), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM), paternal grandfather (PGF)

Diabetes	Bleeding disorder
Stroke	Clotting disorder
Heart disease	Blood clot/Pulmonary embolism
High blood pressure	Anemia
Birth defects	Thyroid disease
Ovarian cancer	Osteoporosis
Colon cancer	Depression
Breast cancer	Alcohol/drug abuse
Other cancer	Type:

HABITS

	Y	N				Y	N	
Smoking			Pack/day/wk	X Yrs	Regular Exercise			
Alcohol			Drinks/Day	Week	Self Breast Exam			
Drug Use					Calcium Intake			
Seat Belt Use					Special Diet			

ALLERGIES		CURRENT MEDICATIONS (Include Vitamins and Herbs)	
MEDICATION	REACTION	NAME	DOSAGE