Carteret Ob Gyn Associates
3511 John Platt Drive, Morehead City, NC 28557 (p)252-247-4297
666 West Corbett Ave, Swansboro NC 28584 (p) 910-325-8612

Patient Medical History Form

The following information is very important to your health. Please take the time to fully and completely fill out this important information.

Patient Name____ Date of Birth ______/______/________

Phone Number_________________________ Race ________________ Ethnicity ___________________

Mailing Address ____

Employer ____ Occupation ________________________

Work Address ____

Emergency Information ____

Primary care physician ____________________________________ Phone ______________________

Other medical providers (ex. dermatologist, cardiologist, internist, surgeon, etc): ______________________________
Phone ______________________

Preferred local pharmacy ______________________________ mail pharmacy _________________________

Preferred mode of notification: ______ mail ______ phone ______email ______text Email Address:_______________________

ALLERGIES

List all medication allergies and reactions:

______________________________ ______________________________

______________________________ ______________________________

List all food allergies and reactions:

______________________________ ______________________________

List all environmental/contact allergies:

______________________________ ______________________________

MEDICATIONS

List all present medications and dosage:

________________ ________________ ________________ ________________

List all present vitamins and dosage:

________________ ________________ ________________ ________________

IMMUNIZATIONS

Type	Date Done
Flu	
Pneumonia	
Gardasil	
Hep B	
Hep A/B (Twinrix)	

GYN HISTORY

Test	Date Last Done
Bone Density	
Colonoscopy	
Mammogram	
Pap Smear	

Primary birth control method ____ Age of first menstrual period _______________

Number of sexual partners (at present) _________________________________ Age of menopause _______________

Age became sexually active _________

PREGNANCIES

# of pregnancies ________ # of abortions ________

# of miscarriages ________ # of live births ________

Any complications with pregnancy? ____yes ____ no If yes, please explain ____

FAMILY HISTORY

	Blood Relative with	Relationship	Age at Onset
	Breast Cancer Yes No		
	Uterine Cancer Yes No		
	Ovarian Cancer Yes No		
	High blood pressure Yes No		
	Heart Disease Yes No		
	Colon Cancer Yes No		
	Osteoporosis Yes No		
	Diabetes Yes No		

Other family history ____

SOCIAL HISTORY

Tobacco use ____ yes ____ no If yes, please explain ______________________________________

Alcohol use ____ yes ____ no ____

Drug use______yes____ no ____

Caffeine use ____ yes ____ no ____

Domestic violence ____ yes ____ no ____

Sexual abuse ____ yes ____ no ____

History of rape ____ yes ____ no ____

SURGICAL HISTORY

Date	Procedure

Any complications with anesthesia? ____yes ____ no If yes, please explain ____

PAST MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
CANCER			EYES			ORTHO		
Breast			Vision Loss/Macular Degeneration			Chronic Back Pain		
Cervical			GASTROENTEROLOGY			Degenerative Joint Disease		
Colon			Colon Polyps			Fractures		
Endometrial			Crohn's/Ulcerative Colitis			PSYCHOLOGICAL		
Lung			Gallbladder Problems			ADD		
Ovarian			Hemorrhoids			Anxiety Disorder		
Skin			Irritable Bowel Syndrome			Bipolar Disease		
Vaginal			Liver Disease/Hepatitis			Depression		
Vulvar			Reflux/Stomach Ulcers			Eating Disorder		
CARDIAC			Vitamin Deficiency			PMS/PMDD		
Aneurysm			HEMATOLOGY			PULMONARY		
Irregular Heart Rate			Anemia			Asthma		
Heart Disease			Bleeding Disorder			COPD/Emphysema		
High Blood Pressure			Blood Clotting Disorder			Seasonal Allergies		
High Cholesterol			DVT/Pulmonary			Sleep Apnea		
DERMATOLOGY			IMMUNITY			RHEUMATOLOGY		
Acne			Chicken Pox/Shingles			Arthritis		
Eczema/Psoriasis			HIV			Autoimmune Disease		
EAR, NOSE, AND THROAT			Rheumatic Fever			Fibromyalgia		
Hearing Loss			Tuberculosis/Positive PPD			Restless Leg Syndrome		
ENDOCRINOLOGY			Usual Childhood Diseases			UROLOGY		
Diabetes			NEUROLOGY			Frequent UTI		
History of Gestational Diabetes			Headaches/Migraines			Blood in Urine		
Elevated Prolactin			Memory Loss/Dementia			Interstitial Cystitis		
Osteopenia			Neuropathy			Kidney Disease		
Thyroid Problems			Seizures/Epilepsy			Kidney Infection		
			Stroke/TIA			Urinary Incontinence		
						Weight Management		