**SOUTHSIDE OB-GYN, P.C.**

PERSONAL HEALTH HISTORY

**Patient Name:**_____ **Age:**_____ **Date of Birth:**____/____/____

**Reason for Visit today:**_____

_____

**Number of Pregnancies:**_____ **Number of Children:**_____ **Number of Abortions/Miscarriages:**_____

**Age When Periods Started:**_____ **Date of Last Menstrual Period:**_____ **How Often?**_____ **Length of Period?**_____

**How Is Your Bleeding During Your Cycle?** Light Moderate Heavy **Birth Control Used:**_____

**Allergies:**_____

**Current Medications:**_____

Past Surgeries:_____

Do You Smoke?_____ If Yes, How Much?_____ Alcohol?_____ Drug Use?_____

## Do YOU or any of your IMMEDIATE Family Members (Parents, Siblings, Grandparents) have a history of the following health issues?

| HEALTH ISSUES | YOU? | FAMILY MEMBERS? | WHICH FAMILY MEMBER? PLEASE ADD ANY OTHER PERTINENT INFORMATION |
|---|---|---|---|
| HEADACHES OR MIGRAINES | YES NO | YES NO | |
| EYES, EARS, NOSE OR THROAT | YES NO | YES NO | |
| HIGH BLOOD PRESSURE, STROKE, HEART ATTACKS, HIGH CHOLESTEROL | YES NO | YES NO | |
| RESPIRATORY DISEASE (LUNGS) | YES NO | YES NO | |
| BREAST CANCER OR BREAST DISEASE | YES NO | YES NO | |
| LIVER DISEASE, HEPATITIS, JAUNDICE | YES NO | YES NO | |
| GALL BLADDER DISEASE | YES NO | YES NO | |
| GASTROINTESTINAL DISEASE SUCH AS ULCERS OR BOWEL PROBLEMS | YES NO | YES NO | |
| KIDNEY DISEASE OR URINARY TRACT PROBLEMS | YES NO | YES NO | |
| ANEMIAS OR BLOOD DISORDERS | YES NO | YES NO | |
| VARICOSE VEINS OR PHLEBITIS | YES NO | YES NO | |
| DIABETES | YES NO | YES NO | |
| THYROID DISEASE | YES NO | YES NO | |
| EPILEPSY OR SEIZURES | YES NO | YES NO | |
| CANCER | YES NO | YES NO | |
| GENETIC DISORDERS/BIRTH DEFECTS | YES NO | YES NO | |
| OTHER HEALTH ISSUES | YES NO | YES NO | |
| | | | |

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____