PATIENT FULL NAME: _____ DATE: _____

PATIENT DATE OF BIRTH: _____

MEDICAL HISTORY:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SURGICAL HISTORY:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

LIST OF MEDICATIONS/DOSAGES/HOW OFTEN (INCLUDING DIET SUPPLEMENTS/VITAMINS)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES AND REACTIONS

1. _____
2. _____

SOCIAL HISTORY:

1. Current smoker? YES NO; If YES, please indicate start date _____How many per day? _____
   If NO, do you have a history of smoking? YES / NO; If yes, please indicate quit date _____
2. History or current use of illegal or recreational substances? YES / NO
   If YES, indicate start/last used date, type of drug, and how much per day _____
3. Current or any use of Alcohol? NO/YES, if so how may drinks daily _____ Weekly_____

MEDICAL FAMILY HISTORY:

1. _____ 2. _____

GYNECOLOGICAL HISTORY:

1. DATE OF LAST MENSTRUAL CYCLE: _____
2. AGE AT FIRST MENSTRUAL CYCLE: _____
3. HOW OFTEN DO YOU HAVE YOUR CYCLES? _____
4. HOW MANY DAYS DO YOUR CYCLES LAST?_____
5. HISTORY OF ABNORMAL PAP SMEARS? _____
6. HISTORY OF SEXUALLY TRANSMITTED DISEASE(S)? _____
7. CURRENT BIRTH CONTROL METHOD: _____

OB PATIENTS: PLEASE LIST YEARS OF ALL PREGNANCIES AND OUTCOMES

1. _____
2. _____
3. _____
4. _____

Dr. Debora Sedaghat / Diplomate, American Board of Obstetrics & Gynecology
11100 Warner Ave, Suite 106, Fountain Valley CA 92708• p(714)966-2112• f(714)966-2335
www.OCWomensCare.com