Medical History Form

Santa Fe Ob/Gyn

Today's date _____

Appointment date _____

Santa Fe Ob/Gyn and Dr. Lynore Martinez
405 Kiva Court, Santa Fe NM 87505
Phone (505) 988-4922 Fax (505) 988-4924
www.santafeobgyn.com

Name: _____
(First) (Middle) (Last)

Date of birth: _____

Pharmacy: _____
(Name) ocation) (Fax number) (Ph number)

Primary Care Physician: _____

What are your primary concerns today? _____

Please complete this form, and

- Mail form to us (address above) one week before your appointment, or
- Fax to us at (505) 988-4924, or
- Bring to your appointment. If you do not mail or fax the form you **MUST ARRIVE** 30 minutes before your appointment time, or your appointment may be rescheduled.

If you have had any of the following medical problems in the past, please indicate by checking box.

Past Medical History

Gynecologic
- ☐ Abnormal pap smear
- ☐ DES Exposure
- ☐ Endometriosis
- ☐ Fibroids (Uterine Fibroids)
- ☐ Ovarian Cysts that required surgery
- ☐ Sexually transmitted diseases (STDs) Type _____
- ☐ Other: _____

Breast
- ☐ Breast Cancer ☐ left right ☐
- ☐ Breast Implants
- ☐ Breast lumps – Requiring Surgery Surgery Type _____
- ☐ Other: _____

Cardiovascular
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Mitral valve prolapse/murmur
- ☐ Other: _____

Digestive
- ☐ Colitis/Crohns/IBS (Circle One)
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Reflux disease (GERD)
- ☐ Stomach ulcer
- ☐ Other: _____

Endocrine
- ☐ Autoimmune disease
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other: _____

Hematologic
- ☐ Anemia
- ☐ Blood clotting disorders
- ☐ Sickle cell
- ☐ Other: _____

Injury/Poisonings
- ☐ Fractures Date _____ Description _____
- ☐ Motor vehicle accident Requiring Hospitalization? _____ Date _____
- ☐ Other (injury/poisonings): _____

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus
- ☐ Other: _____

Cancer of...
- ☐ Colon
- ☐ Ovary
- ☐ Skin
- ☐ Uterus
- ☐ Other: _____

Neurologic
- ☐ Migraines
- ☐ Seizures
- ☐ Strokes
- ☐ Other: _____

Psychiatric
- ☐ Anxiety disorder
- ☐ Depression
- ☐ Post Partum Depression
- ☐ Other: _____

Respiratory
- ☐ Asthma
- ☐ Emphysema COPD
- ☐ Other: _____

Urologic
- ☐ Frequent urinary infections
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Other: _____

Other:

Date of Last Pap Smear: _____	**Normal**	**Abnormal**	**Date of Last Mammogram:** _____	**Normal**	**Abnormal**
Date of Last Bone Density Scan: _____	**Normal**	**Abnormal**	**Date of Last Colonoscopy:** _____	**Normal**	**Abnormal**
Date of Last Cholesterol Screen: _____	**Normal**	**Abnormal**			

Please list (below) any prior surgeries you have had, including wisdom teeth removal, tonsillectomy, appendectomy, etc.

Surgery/Reason	**Date**	**Surgery/Reason** (cont'd)	**Date**

CURRENT MEDICATIONS: (List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications You may use additional pages if necessary. Also, please bring all your medications with you to your appointment.)

Medication	Strength	How Often	Prescribed By	Reason

Please list known allergies and reactions to medications or substances (e.g., latex, iodine, etc.)

☐ No Known Allergies		Allergy	Reaction
Allergy	Reaction	Allergy	Reaction
Allergy	Reaction	Allergy	Reaction
Allergy	Reaction	Allergy	Reaction

FAMILY HISTORY: ***(Please check if any of your family members have had the following)***

Adopted? ☐ Yes No ☐

ILLNESS	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle	Age of Onset
Blood clot in leg / lungs (circle one)											
Cancer, Breast											
Cancer, Colon											
Cancer, Ovarian											
Cancer, Uterine											
Cancer, Other (write below) _____											
Cardiovascular Disease											
Depression											
Diabetes											
Hypertension											
Osteoporosis											
Polyp - anal/rectal/colon											
Stroke											
Thyroid Disorder											
High Cholesterol											

Reproductive History

Age of first menses (period):	Cycle Interval (Number of days from start to start):
Menses duration (Number of days of bleeding):	Flow (Light, Medium, or Heavy):
Number of Tampons/day:	Number of Pads/day:
Last Menstrual Period: / / (Date)	Certain of Last Menstrual Period Date (yes or no)?
Menopause Status (Pre, Peri or Post):	Age at Menopause:
Method of Birth Control:	Clots (yes or no)?
Bleeding between periods (yes or no):	On Hormone Replacements (yes or no)?

Prenatal Summary

Total # of Pregnancies	Ectopic or Tubal Pregnancies
Living Children	Miscarriages
Full Term Births	Abortions, Induced
Premature Births	

Pregnancy Details (if child bearing age)

Birth Date	Gestational Weeks	Hours in Labor	Baby's Weight	Baby's Sex	Type of Delivery	Anesthesia	Any Preterm Labor?	Complications	Child's Name	Hospital

Social History

Marital Status ____Dating	____Divorced	____Engaged	____Married	____ Not Dating ____Single ____Widowed
Spouse/Partner Name:			Your Occupation:	
Alcohol: _____Never	_____Current	_____Former	Amount per Week:	
Caffeine _____Never	_____Current	_____Former	Amount per Day:	
Drugs: _____Never	_____Current	_____Former	Type:	
Smoking: _____Never	_____Current	_____Former	Amount per Day:	
Exercise: _____None (Sedentary)	_____Minimal (once/week or less)	_____Moderate (1-3 times/week)	_____Heavy (4 or more times/week)	
Have you been sexually, physically, emotionally abused, threatened or hurt by anyone? ☐ Yes ☐ No				