SOUTHFIELD OB/GYN ASSOCIATES
29275 Northwestern Highway, Suite 207
Southfield, MI 48034
(248) 354-2201

Patient Self-History Form

Date _____

Patient Name _____

Birth Date _____ Soc. Sec. No. _____

Marital Status: S M D W

Phone: ( ) _____ Work Phone: ( ) _____

Address _____

City/State/Zip _____

Emergency Contact (Name & Phone) _____

Previous Physician's Name and Address: _____

_____

Have you ever had a MAMMOGRAM? ☐ Yes ☐ No If yes, when? _____

Date of last Pap Smear _____ Date of last menstrual period _____

Age at first period _____ How heavy is your flow? _____

How many days from the beginning of one period to the next? _____

Do you have discomfort with your periods? ☐ Yes ☐ No If yes, explain: _____

_____

Do you take medication or do anything for the discomfort? ☐ Yes ☐ No If yes, what _____

_____

Are you allergic to any medications? ☐ Yes ☐ No Penicillin _____ Codeine _____

Iodine _____ Tape _____ Other _____

List all medications that you are presently taking _____

_____

Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No

What is your present method of birth control? _____

Total pregnancies: Full Term _____ Pre-Term _____ Miscarriages _____

Abortions _____ Living Children _____ Adopted Children _____

Do you wear glasses? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No Other _____

Have you ever had surgery? ☐ Yes ☐ No If yes, what and when? Explain _____

_____

Have you ever been in any major accidents? ☐ Yes ☐ No If yes, explain _____

_____

Do you have or has anyone in your family had any of the following: Check all that apply.

If so, please write in who has/had the condition:

Heart disease or murmur _____ Kidney/Liver disease _____

High Blood Pressure _____ Hepatitis _____

Migraine Headaches _____ Blood Clots _____

Cancer _____ Constipation _____

Breast Cancer _____ Ulcers _____

Lung Problems _____ Thyroid Condition _____

Tuberculosis _____ Severe Depression _____

Pneumonia _____ Suicidal Thoughts _____

Asthma _____ Nervous Condition _____

Epilepsy _____ Arthritis _____

Stroke _____ High Cholesterol _____

Endometriosis _____ Fibroids _____

Diabetes _____

Do YOU have or have YOU had any of the following: Check all that apply.

Anemia (Low Blood Count) _____ HIV _____

Blood Transfusions _____ Herpes _____

Urinary Tract/Bladder Infection _____ Syphilis _____

Hemorrhoids _____ Gonorrhea _____

Infertility _____ Chlamydia _____

Painful Periods _____ Crabs _____

Pelvic Infections _____ Trichomoniasis _____

Abnormal Bleeding _____ Genital Warts _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How long? _____

Do you drink coffee/tea? ☐ Yes ☐ No If yes, how much per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per day? _____

Do you drink cola? ☐ Yes ☐ No If yes, how much per day? _____

Have you ever used marijuana? ☐ Yes ☐ No Cocaine? ☐ Yes ☐ No Heroine? ☐ Yes ☐ No

Other? _____

Your level of education:

Grade School: _____ High School: _____ College: _____ Post Graduate: _____

Thank you very much for taking the time to complete this questionnaire. The answers you have provided will help us further plan your care. If you feel there is anything else we need to know about you, you can write it below in the space provided or wait and discuss it with the Doctor on your first visit.

_____

_____

_____

_____