

MISSION OB/GYN - ESTABLISHED PATIENT FORM

PATIENT NAME _____ DOB ____ / ____ / ____ AGE _____

PHARMACY AND PHARMACY NUMBER

TODAY'S DATE:

INDICATION/REASON FOR VISIT:

Last pap _____ (abnl? _____) Last mammo _____ Last colonoscopy _____ Last DEXA _____

PREGNANCY:

Total pregnancy # _____

Full term _____ Premature _____ Voluntary _____ Miscariages _____ Ectopics _____ Multiples _____ Living _____

MENSTRUAL HISTORY:

LMP _____

Current method of birth control _____

Menopausal? Any breakthrough bleeding? HRT?

MEDICATIONS:

Current medications: Dose/how often per day: Indication/Reason:

ALLERGIES: Any allergies? If yes - what was the reaction: _____ No Known Drug Allergies

NEW MEDICAL HISTORY:

ANY RECENT SURGERIES:

SOCIAL HISTORY:

Smoking (amount) - if former smoker quit date

Occupation

Relationship status (verify) Dating Divorced Engaged Married Same Sex Couple Single Widowed

Sexually active (yes/no)

MISSION OB/GYN - ESTABLISHED PATIENT FORM

UPDATE FAMILY HISTORY:

Blood Clots Breast /Colon /Ovarian/Other CA Diabetes Heart Disease High Blood Pressure Stroke