

MT. PLEASANT OB/GYN, P.A. — 1400 Hospital Drive, Mt. Pleasant, South Carolina 29464

NAME: _____ BIRTHDATE: _____ DATE: _____

MEDICAL HISTORY (X if positive)

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle problems |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Bone problems |
| <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Nerve problems |
| <input type="checkbox"/> Problems with anesthesia | <input type="checkbox"/> Exposure to toxic chemicals |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> or radiation |

FAMILY HISTORY (X if positive)

- | | |
|--|---|
| <input type="checkbox"/> Cancer of breast | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer of female organs | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Other cancer | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genetic diseases |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Other _____ | |

HABITS: Alcohol (amt.) _____ Cigarettes (amt.) _____ Other _____

HOSPITALIZATIONS AND OPERATIONS (DO NOT INCLUDE OBSTETRICAL DELIVERIES)

Date	Operation and/or Reason for Hosp.	Findings and Complications

CURRENT MEDICATIONS

ALLERGIES

Drug and Dose	Reason	Start	Stop	Drug or Substance	Reaction	Date