Lawrence OB-GYN Specialists
LMH Health

If you have filled this form out in the last 12 months, please disregard!

NAME: _____ DOB: _____ PHONE NUMBER: _____ Date: _____

What is the reason for your appointment today? □ YEARLY EXAM □ OTHER: _____

Allergies to medications:_____

PRESCRIPTION MEDICATIONS/DOSAGE	OVER THE COUNTER MEDICATIONS	VITAMINS/SUPPLEMENTS

INSURANCE: _____ PHARMACY OF CHOICE: _____

PRIMARY CARE PHYSICIAN: _____ FIRST DAY OF LAST MENSTRUAL PERIOD: _____

MEDICAL/SOCIAL HISTORY:

Have you had a pap smear? YES NO Date of last exam: _____
Have you had a mammogram? YES NO Date of last exam: _____
Have you had a bone density scan? YES NO Date of last exam: _____
Have you had a colonoscopy? YES NO Date of last exam: _____
Have you completed the Gardasil vaccine series for HPV? YES NO
Have you had a vaccine for Covid-19? YES NO Date of most recent dose: _____

Tobacco use: YES NO PAST Current use per day: _____ Stopped at age: _____

Alcohol use: YES NO PAST Current number of drinks per day/week/month/year: _____

Substance use: YES NO PAST Specific substance: _____

Exercise: YES NO What type: _____

STUDENT RETIRED UNEMPLOYED EMPLOYED/CURRENT OCCUPATION: _____

Have you ever been sexually active? YES NO
Number of current sexual partners: _____ Total number of lifetime sexual partners: _____
Sexual orientation: Straight/heterosexual I Lesbian/Gay I Bisexual I Queer/Pansexual I Biromantic/Asexual I Prefer not to answer

My preferred pronoun: SHE/HER HE/HIM THEY/THEM Other preference: _____ Birth control: YES NO
Current method of birth control: _____

STD history: YES NO Type of STD (if known): _____

Do you feel the need to report or have any concerns regarding:
Sexual abuse: PAST PRESENT NONE
Verbal abuse: PAST PRESENT NONE
Physical abuse: PAST PRESENT NONE

Have you been diagnosed with any of the following medical conditions?

ABNORMAL PAP SMEAR	DEPRESSION	KIDNEY DISEASE
ANXIETY	DIABETES	LIVER DISEASE
ANOREXIA	ENDOMETRIOSIS	OSTEOPENIA/OSTEOPOROSIS
ASTHMA	EPILEPSY/SEIZURES	THYROID DISEASE
BLEEDING DISORDER	HEART DISEASE	UTI PROBLEMS
BLOOD CLOT(S)	HIGH BLOOD PRESSURE	VEIN DISORDER/DISEASE
BULIMIA	HIGH CHOLESTEROL	OTHER: _____
CANCER (TYPE): _____	INFERTILITY	_____

SURGICAL/PROCEDURE HISTORY:

NAME OF SURGERY/PROCEDURE	DATE/YEAR PERFORMED	DID YOU HAVE ANY COMPLICATIONS?

FAMILY HISTORY: **□ ADOPTED and/or HISTORY UNKNOWN**

DISEASE/CONDITION	MOTHER	FATHER	BROTHER	SISTER	GRANDMA	GRANDPA	CHILD
Bleeding disorder					Maternal/Paternal	Maternal/Paternal	
Blood clot(s)					Maternal/Paternal	Maternal/Paternal	
Cancer					Maternal/Paternal	Maternal/Paternal	
Diabetes					Maternal/Paternal	Maternal/Paternal	
Heart disease					Maternal/Paternal	Maternal/Paternal	
High blood pressure					Maternal/Paternal	Maternal/Paternal	
High cholesterol					Maternal/Paternal	Maternal/Paternal	
Kidney disease					Maternal/Paternal	Maternal/Paternal	
Liver disease					Maternal/Paternal	Maternal/Paternal	
Stroke					Maternal/Paternal	Maternal/Paternal	
Thyroid disease					Maternal/Paternal	Maternal/Paternal	
Other: _____					Maternal/Paternal	Maternal/Paternal	

OBSTETRICAL (PREGNANCY) HISTORY:

DATE OF DELIVERY	SEX	WEIGHT	# OF WEEKS AT DEL.	VAGINAL	C-SECTION	MISCARRIAGE	ABORTION	STILLBIRTH	COMPLICATIONS

MENSES (PERIOD) HISTORY:

How old were you when your period started? _____

How frequently do you have your period? _____

How long does your period last? _____

How many pads and/or tampons do you use during the heaviest days of your period? _____

Are you postmenopausal? _____ Year or age of menopause? _____

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MEDICAL RECORDS REQUEST FOR CONTINUATION OF PATIENT CARE

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Requesting medical records from:

Provider or clinic name: _____

Phone Number: _____

Fax Number: _____

Please forward the above patient's medical records to the following provider:

Provider Name: _____

Clinic Name: _____LAWRENCE OB/GYN SPECIALISTS_____

Phone Number: ___785-505-4950 option 2_____ Fax

Number: _____785-505-5240_____

Information to be disclosed (please circle):

□ Emergency room record	□ History and physical	□ Complete medical record
□ Laboratory reports	□ Consultation	□ Prenatal care/delivery report
□ Radiology reports	□ Operation/procedure	□ Gynecology care
□ Pathology reports	□ Final case summary	□ Other

_____

_____

_____

Covering the period of healthcare from: Date(s):_____ to _____

Signature: _____ Date: _____

(Patient or authorized person)