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

Please turn over and complete back

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

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

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? _____