Greenville OB GYN Clinic

Dr. Marie Hollis, M.D.

Patient Name:_____Date of Birth_____

Reason for Visit

What brings you in today?_____

_____

_____

_____

What other concerns would like to address?

_____

_____

_____

Current Medications

What medications are you taking?_____

Name	Dose	Frequency

Allergies

Are you allergic to: ☐ Tape ☐ Latex ☐ Iodine

Name	Reaction

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Autoimmune Disorders
- ☐ Back problems
- ☐ Bleeding
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Clotting Disorder
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorders
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Defects
- ☐ Hepatitis A,B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disorder
- ☐ Kidney Disorder
- ☐ Joint Disorder
- ☐ Lung Disorder
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Illness
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Skin Disorder
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease

Other details:_____

_____

_____

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Other details:_____

_____

_____

Past Surgical History

Surgery	Date	Where Performed
Surgery	Date	Where Performed
Surgery	Date	Where Performed
Surgery	Date	Where Performed
Surgery	Date	Where Performed
Surgery	Date	Where Performed

Lifestyle

Are you sexually active? ☐ Yes ☐ No How many partners? (past year)_____ (total lifetime)_____

If not currently active, have you ever been sexually active? ☐ Yes ☐ No

Sexual Partner(s) is/are: ☐ Male ☐ Female ☐ Both

Would you like to be checked for sexually transmitted diseases? ☐ Yes ☐ No

Has anyone in your home physically or verbally hurt you? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No packs/day_____ Have you ever smoked? ☐ Yes ☐ No Quit Date_____

Do you use recreational drugs? ☐ Yes ☐ No What types/Frequency_____

How much alcohol do drink per week?_____

How much caffeine do you drink per day?_____

How many times per week do you exercise?_____

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Pregnancy History

# pregnancies	#term	#preterm	#miscarriages	#abortions

Date	#Weeks	Type of Delivery	M/F	Weight	Living	Complications

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

What is your current method of birth control? ☐ N/A ☐ Abstinence ☐ Condoms

☐ Intrauterine Device ☐ Implanon/Nexplanon ☐ Vaginal Ring (Nuva Ring) ☐ Contraceptive Patch

☐ Spermicide ☐ Natural Family Planning/Rhythm Method ☐ Withdrawal ☐ Diapragm/cervical cap

☐ Oral contraceptive Pills: (name)_____ ☐ Other:_____

Menstrual History

Age at first period?_____

Date of last period?_____

Frequency of periods?_____

Length of period?_____

Are your periods regular? ☐ Yes ☐ No

Age at menopause?_____

Health Maintenance

Last pap smear _____

Last mammogram _____

Last colonoscopy _____

Last bone density _____

Last general health checkup _____

Immunizations up to date? ☐ Yes ☐ No

OB/GYN History

☐ Abnormal vaginal bleeding
☐ Abnormal pap smear
☐ Bleeding between periods
☐ Breast Lump/Mass
☐ Breast Cancer
☐ Breast Surgery
☐ Cervical Cancer
☐ Cervical Dysplasia
☐ Chlamydia
☐ Colposcopy previously
☐ Cryosurgery
☐ DES exposure
☐ Fecal/Flatus Incontinence
☐ Fibroids
☐ Genital Warts
☐ Gonorrhea
☐ Herpes
☐ Hot Flashes
☐ HPV (Human Papilloma Virus)
☐ Infertility
☐ Irregular Periods
☐ Menstrual Pain
☐ Nipple Discharge
☐ Ovarian cysts
☐ Ovarian Cancer
☐ Painful Intercourse
☐ Pelvic Inflammatory Disease
☐ Uterine Cancer
☐ Uterine Hyperplasia
☐ Urinary Incontinence
☐ UTI – frequent
☐ Vaginitis (BV) – frequent
☐ Yeast - frequent