Far Hills OB/GYN, Inc.

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS ON THIS FORM

Date_____

Patient's name_____ Birth date_____

Who referred you here? _____

What is your main problem for coming to the doctor today? _____

_____

_____

Are you taking any medicines, including birth control pills? Please list all medications:_____

_____

_____

Which type of birth control to you use if any?_____

Are you allergic to any medications? If you have any allergies please list reaction you have had:_____

_____

When did your last period start? _____

When was your last pap smear? _____

Have you ever had an abnormal pap smear, if so, please list date with results:_____

Have you ever had herpes or any sexually transmitted diseases? Please list:_____

_____

Have you had previous surgery? _____

Dates & Types: 1._____

2._____

3._____

4._____

5._____

If you have had any pregnancies, including miscarriages or others, please list all:

	Date	Length of Labor (Hours)	Sex	Birth Weight	Complications
1.					
2.					
3.					
4.					
5.					
6.					