

# SALINA Women's CLINIC

Obstetrics and Gynecology  
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## PATIENT ASSESSMENT

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Reason for visit \_\_\_\_\_

Employer/School \_\_\_\_\_

Medication Allergies \_\_\_\_\_

## YOUR PERSONAL MEDICAL HISTORY

Height \_\_\_\_\_ Race (optional) \_\_\_\_\_

Do you have any of the following?

- Diabetes       High Blood Pressure       Heart Disease       Stomach Problems  
 Cancer       Seizures       Other \_\_\_\_\_

## OBSTETRICS

Total number of pregnancies (Including current pregnancy, miscarriages, and/or abortions) \_\_\_\_\_

Number of: living children \_\_\_\_\_ deceased children \_\_\_\_\_ miscarriages \_\_\_\_\_ abortions \_\_\_\_\_

## PAST SURGERIES AND YEAR PERFORMED

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICATIONS (on daily basis; put any additional meds on back of page)

NAME	DOSAGE	NAME	DOSAGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## SOCIAL HISTORY

Do you smoke?  Yes  No      How many daily? \_\_\_\_\_      Number of packs per day? \_\_\_\_\_

If you quit, how long ago? \_\_\_\_\_

Alcohol intake  Socially  Daily

Marital Status  Single  Married  Divorced  Separated  Widowed

Are you sexually active?  Yes  No      What type of birth control do you use? \_\_\_\_\_

Do you have any of the following?  Special diet  Glasses  Contacts  Dentures  Hearing Aids

Do you have any metals in your body?  Yes  No      If yes, where? \_\_\_\_\_

Are you claustrophobic?  Yes  No      Are you allergic to any dyes, seafood, or iodine?  Yes  No