plaza OB/GYN www.plazaobg.com PH: 713.522.3333 FX: 713.522.4434 1801 BINZ STREET, SUITE 500 HOUSTON, TEXAS 77004

MEDICAL HISTORY INFORMATION

Please Print Clearly Acct. #_____ Date _____

Name _____ DOB: _____Age _____
(Last, Middle I. First)

Preferred Pharmacy Name: _____ Pharmacy Phone#:_____

Last Menstrual Cycle ____/____/____ Last Pap Smear Taken ___/____/_____ Last Mammogram ___/____/_____
Facility _____

Why are you seeing the Doctor today? _____

_____

Who referred you to our practice? _____

Do you have an advance directive or living will? Yes / No

FAMILY HISTORY

High blood pressure/Heart Disease _____

Diabetes _____

Breast Cancer _____

Ovarian Cancer _____

OBSTETRICAL HISTORY

Total Pregnancies _____ Full Term _____ Premature ____Terminations ____ Miscarriages _____

Your Pregnancies:

DOB	Weight	SEX	VAGINAL OR C-SECTION

Medical _____

_____

Surgical History _____

_____

Current Medication list & reason for medication _____

_____

Any Known allergies to medications? If so,what? _____

_____

I certify that the above information is accurate to the best of my knowledge.

Preferred Contact _____ OK to leave message with results Yes / No

Signature (parent or guardian if patient is minor) _____

Print Name _____