OB-GYN WOMEN PHYSICIANS ASSOC., INC.
NILIMA PAREKHJI, M.D., F.A.C.O.G.
SARITA JOHNSON, M.D.

PLEASE PRINT

DATE: _____ PHONE: _____

NAME: _____ AGE: _____ BIRTHDATE _____

CHIEF COMPLAINT — REASON FOR VISIT: _____

_____

_____

PAST MENSTRUAL HISTORY:

MENSTRUAL PERIODS: LAST PHYSICAL & PAP _____ WITH DR. _____

AGE AT ONSET: _____ FREQUENCY: _____ DURATION: _____ CRAMPS: _____ CLOTS: _____

CONTRACEPTION: PAST: _____ PRESENT: _____ FUTURE: _____

PAST OBSTETRIC HISTORY: _____

NO. OF PREGNANCIES: _____ NO. OF LIVING CHILDREN: _____ AGE: _____

NO. OF MISCARRIAGES: _____ NO. OF ABORTIONS: _____

LAST DELIVERY: _____ ANY COMPLICATIONS: _____

PERSONAL HISTORY:

HEIGHT: _____ USUAL WT: _____ BLOOD TYPE: _____

SURGERY WITH DATES: _____

SERIOUS ILLNESS: _____

FAMILY HISTORY: MOTHER L D CAUSE: _____ FATHER L D CAUSE: _____

SIBLING LIVING _____ DEAD _____ CAUSE: _____

DOES YOUR MEDICAL HISTORY INCLUDE:	Yes	No.	ELABORATE
Allergy. Drug sensitivity			
Anemia. Blood disorder			
Clotting problem			
Blood transfusion			
Multiple birth			
Birth defect or inherited disease			
Herpes, V.D.			
DES exposure			
Abnormal Pap smear			
Sexual problem			
Vaginal or pelvic infection			
Tobacco, alcohol, or other drug use			
Recent weight change			
Routine medications			
Frequent headaches. Visual problems			
Depression			
Seizure. Nervous disorder			
Heart trouble. Blood pressure changes			
Breast problems			
Abdominal pain. Digestive or bowel problems			
Kidney or bladder difficulty			
Other medical problems			
Heart disease, cancer, diabetes, bleeding disorder or other possibly familial disease in your family			