

# Brad Moore, MD Ob/Gyn, PC

## HEALTH ASSESSMENT

If you are not new to this practice, please fill out only changes in your medical history.

Name \_\_\_\_\_

Date \_\_\_\_\_

What is the main purpose of your visit today?


### PAST MEDICAL HISTORY

Please indicate any PAST or CURRENT medical problems

Heart Disease	High Blood Pressure	Epilepsy/Seizures
Lung Disease (including Asthma)	Blood Transfusion	Breast Cancer/Biopsies
Stomach Problems	Diabetes	DES Exposure
Urinary Problems	Venereal Disease/STD	Pelvic Inflammatory Disease (PID)
Muscles/Bones Problems	Mental Illness/Depression	Tumor of Any Kind
Thyroid Disease	Blood Disease	Migreaine Headaches
Any conditions not listed?		

### SURGERY OR MAJOR HOSPITALIZATIONS

Reason:	Month/Year	Reason:	Month/Year

DRUG ALLERGIES	Reaction	In your family, do you have any of the following?			
		Disease:			Relationship
		Heart Disease	Yes	No	
		Hypertension	Yes	No	
		Stroke	Yes	No	
CURRENT MEDICATIONS	Dose	Breast Cancer	Yes	No	
		Colon Cancer	Yes	No	
		Other Cancers	Yes	No	
		Diabetes	Yes	No	
		Epilepsy	Yes	No	
		Bleeding disorder	Yes	No	
		Kidney disease	Yes	No	
		Thyroid disease	Yes	No	
		Mental Illness	Yes	No	
		Others not listed	Yes	No	

Occupation: \_\_\_\_\_

Do you Smoke: No Yes How Much?	Are you exposed to any chemicals at work that may harm you or your unborn child? No Yes
Do you Drink: No Occasionally Yes	
Do you use illegal drugs: No Yes Type?	
Marital Status: Single Married Divorced Separated	

Have you ever been the victim of sexual, physical, or mental abuse? No Yes Explain \_\_\_\_\_

### PREGNANCY HISTORY

How many total pregnancies have you had?	(please detail below)		Largest baby?
Type: (vaginal, C-section, miscarriage/abortion)	Month/Yr	#weeks	Complications?

