Greenville OB GYN Clinic

Dr. Marie Hollis, M.D.

Patient Name:_____Date of Birth_____

Reason for Visit

What brings you in today?_____

_____

_____

_____

What other concerns would like to address?

_____

_____

_____

Current Medications

What medications are you taking?_____

Name	Dose	Frequency

Allergies

Are you allergic to: ☐ Tape ☐ Latex ☐ Iodine

Name	Reaction

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Autoimmune Disorders
- ☐ Back problems
- ☐ Bleeding
- ☐ Blood Disorders
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Clotting Disorder
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorders
- ☐ Ear Problems
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Defects
- ☐ Hepatitis A,B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disorder
- ☐ Kidney Disorder
- ☐ Joint Disorder
- ☐ Lung Disorder
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Illness
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Skin Disorder
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease

Other details:_____

_____

_____

Patient Name:_____Date of Birth_____

Family Medical History

☐ Alcoholism	☐ Breast Cancer	☐ Hepatitis A,B, or C	☐ Psychiatric Illness
☐ Allergies	☐ Clotting Disorder	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Anemia	☐ Colon Cancer	☐ High Cholesterol	☐ Stroke
☐ Anxiety	☐ Diabetes	☐ Liver Disorder	☐ Thyroid Disorder
☐ Asthma	☐ Depression	☐ Kidney Disorder	☐ Stomach Ulcer
☐ AIDS/HIV	☐ Eating Disorders	☐ Joint Disorder	☐ Substance Abuse
☐ Autoimmune Disorders	☐ Ear Problems	☐ Lung Disorder	☐ Skin Disorder
☐ Back problems	☐ Epilepsy	☐ Measles	☐ Tuberculosis
☐ Bleeding	☐ Glaucoma	☐ Migraines	☐ Sexually Transmitted Disease
☐ Blood Disorders	☐ Gout	☐ Osteoporosis	
☐ Blood Transfusion	☐ Heart Disease	☐ Pneumonia	
	☐ Heart Defects	☐ Polio	

Other details:_____

_____

_____

Past Surgical History

_____	_____	_____
Surgery	Date	Where Performed
_____	_____	_____
Surgery	Date	Where Performed
_____	_____	_____
Surgery	Date	Where Performed
_____	_____	_____
Surgery	Date	Where Performed
_____	_____	_____
Surgery	Date	Where Performed

Lifestyle

Are you sexually active? ☐ Yes ☐ No How many partners? (past year)_____ (total lifetime)_____

If not currently active, have you ever been sexually active? ☐ Yes ☐ No

Sexual Partner(s) is/are: ☐ Male ☐ Female ☐ Both

Would you like to be checked for sexually transmitted diseases? ☐ Yes ☐ No

Has anyone in your home physically or verbally hurt you? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No packs/day_____ Have you ever smoked? ☐ Yes ☐ No Quit Date_____

Do you use recreational drugs? ☐ Yes ☐ No What types/Frequency_____

How much alcohol do drink per week?_____

How much caffeine do you drink per day?_____

How many times per week do you exercise?_____

Patient Name:_____Date of Birth_____

Pregnancy History

_____	_____	_____	_____	_____
# pregnancies	#term	#preterm	#miscarriages	#abortions

Date	#Weeks	Type of Delivery	M/F	Weight	Living	Complications

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

What is your current method of birth control? ☐ N/A ☐ Abstinence ☐ Condoms

☐ Intrauterine Device ☐ Implanon/Nexplanon ☐ Vaginal Ring (Nuva Ring) ☐ Contraceptive Patch

☐ Spermicide ☐ Natural Family Planning/Rhythm Method ☐ Withdrawal ☐ Diapragm/cervical cap

☐ Oral contraceptive Pills: (name)_____ ☐ Other:_____

Menstrual History

Age at first period?_____

Date of last period?_____

Frequency of periods?_____

Length of period?_____

Are your periods regular? ☐ Yes ☐ No

Age at menopause?_____

Health Maintenance

Last pap smear _____

Last mammogram _____

Last colonoscopy _____

Last bone density _____

Last general health checkup _____

Immunizations up to date? ☐ Yes ☐ No

OB/GYN History

☐ Abnormal vaginal bleeding
☐ Abnormal pap smear
☐ Bleeding between periods
☐ Breast Lump/Mass
☐ Breast Cancer
☐ Breast Surgery
☐ Cervical Cancer
☐ Cervical Dysplasia
☐ Chlamydia
☐ Colposcopy previously
☐ Cryosurgery
☐ DES exposure
☐ Fecal/Flatus Incontinence
☐ Fibroids
☐ Genital Warts
☐ Gonorrhea
☐ Herpes
☐ Hot Flashes
☐ HPV (Human Papilloma Virus)
☐ Infertility
☐ Irregular Periods
☐ Menstrual Pain
☐ Nipple Discharge
☐ Ovarian cysts
☐ Ovarian Cancer
☐ Painful Intercourse
☐ Pelvic Inflammatory Disease
☐ Uterine Cancer
☐ Uterine Hyperplasia
☐ Urinary Incontinence
☐ UTI – frequent
☐ Vaginitis (BV) – frequent
☐ Yeast - frequent