

KAMM MCKENZIE OBSTETRICS & GYNECOLOGY

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NEW PATIENT HISTORY FORM

MISSY BLANCHARD, N.P.
 JANICE ALEXANDER, C.N.M.,M.N
 ANJIE T. KING, F.N.P.-C

CYNTHIA B. SAACKS, M.D.
 ASHLEY N. RUSH, M.D.
 LAUREN M. WHEELER, M.D.

CHART NO. _____

PLEASE PRINT

Age _____ DATE _____

Name _____ Birth Date _____ Marital Status S M W D Sep. Race _____

Address _____ Home Phone _____

Occupation _____ Business Phone _____

SS# _____ Referred By _____ Cell Phone _____

Partner's Name _____ Business Phone _____

Occupation _____ Cell Phone _____

MENSTRUAL HISTORY: Date of last period _____ Regularity _____ Birth Control Method _____

OBSTETRICAL HISTORY: Total # of Pregnancies _____ # Living _____ # Abortions _____ # Miscarriages _____

No.	Date	Place	Wks Gest.	Duration of Labor	Type of Del.	Anesthesia	Sex & Name	Wt.	Complications

SURGICAL HISTORY:

Date	Surgery Performed

MEDICAL HISTORY: (patient and family): (Pt = Patient; F = Family)

Description	Pt	F	Description	Pt	F	Description	Pt	F	Allergies _____
Heart Disease			Diabetes			Anemia/Transfusion			_____
Hypertension			Thyroid Endoc.			Mental/Emotional			_____
Pulmonary Disease			Gyn			Phlebitis			_____
Breast Problems			Herpes			Seizures			Tobacco _____
Hepatitis			Syphilis			Cong. Anomalies			Alcohol _____
Kidney Disease			GC/Chlamydia			Breast Cancer			Drugs _____
Uterine Fibroids			Venereal Warts			Ovarian Cancer			
						Colon Cancer			

OTHER MEDICAL HISTORY: (Explain checked boxes from above)

MEDICATIONS: