Ensley OB/GYN
With you every step of the way

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Initial Patient Self History Form

Please fully complete all pages of this history before you see the doctor. If you do not understand any of the questions, leave them blank.

Patient's Name _____ Age ____ Date of Birth _____/_____/_____
Home Address _____ Home Phone # _____ Cell Phone# _____
City, State Zip code _____,_____ _____ SS# _____-_____-_____ Height _____
Occupation _____ Work # _____ Race or Ethnicity _____ Religion _____Marital Status _____

E-mail Address _____ Primary Care Physician _____

What or who caused you to become interested in seeing Dr. Ensley?_____

Significant Other: _____ Occupation: _____ Work # _____ Home # _____

Relation to Patient (Circle One) : Spouse/ Boyfriend Name: _____ SS#:_____ DOB: _____

1. Reason for Appointment:_____

_____

2.What pharmacy do you use?_____

Medical History

2. Have **you** had any of the following conditions? Has any family members had any of the following? Clinician Comments

(SELF) YES	(SELF) NO		(FAMILY) YES	(FAMILY) NO
( )	( )	a. Diabetes (sugar) ……..	( )	( )
( )	( )	b. High Blood Pressure ……..	( )	( )
( )	( )	c. Heart Disease/Attacks …….	( )	( )
( )	( )	d. Autoimmune Disorder (Lupus / Rheumatoid Arthritis)…….	( )	( )
( )	( )	e. Kidney Disease / Urinary Tract Infection…….	( )	( )
( )	( )	f. Epilepsy / Seizure Disorder…….	( )	( )
( )	( )	g. Mental / Emotional / Depression / Post-Partum Depression…….	( )	( )
( )	( )	h. Hepatitis / Mono / Liver Disease…….	( )	( )
( )	( )	i. Varicose Veins / Phlebitis / Blood Clots in Veins or Arteries…….	( )	( )
( )	( )	j. Thyroid Disease…….	( )	( )
( )	( )	k. Trauma / Motor Vehicle Accident…….	( )	( )
( )	( )	l. Domestic Violence…….	( )	( )
( )	( )	m. Frequent Severe Headaches ……..……..	( )	( )
( )	( )	n. Sickle Cell Trait / Sickle Cell Disease…….	( )	( )
( )	( )	o. Strokes ……..…	( )	( )
( )	( )	p. Endometriosis…….....(	)	( )
( )	( )	q. Fibroids ……..…….…..…(	)	( )
( )	( )	r. Infertility ……..…….	( )	( )
( )	( )	s. Cancer ……..……..…	( )	( )

3. Have you personally ever had any of the following conditions?

YES **NO**

( ) ( ) a. Blood Transfusion
( ) ( ) b. Asthma
( ) ( ) c. TB (Tuberculosis) / lived with someone who had TB
( ) ( ) d. Mitral Valve Prolapse / Need Antibiotics Before Dental Procedures
( ) ( ) e. Stomach/intestinal problems
( ) ( ) f. Gall bladder disease

TYPE OF CANCER	SELF	WHICH RELATIVE
BREAST:		
OVARY:		
COLON:		
UTERUS:		
THYROID:		

( ) ( ) g. Anemia (low blood count)
( ) ( ) h. Rubella (German measles)
( ) ( ) i. Special Immunizations (vaccinations) **Other than Childhood**
Which? _____ When? _____
( ) ( ) j. Other
_____
_____

4. Please list any medications you are taking for the above-mentioned conditions listed under Numbers 2 and 3 (include dosage).
_____
_____

5. Please list any other medications, including the dosages that you are presently taking. Please include all over-the-counter medications, vitamins, minerals, herbs, and all other supplements.
_____
_____

6. Do you smoke? ( ) Yes ( ) No. If yes, how much? ____ppd

If you used to smoke, when did you quit? _____How much did you used to smoke? _____ppd

7. Do you drink alcohol? ( ) Yes ( ) No. If yes, how much?_____drinks per day/week/month/year

(A drink = 12 oz of beer = 5 oz. wine = 1 shot of liquor)

If you quit drinking, when did you quit? _____

How much did you drink before quitting? _____drinks per day/week/month/year

8. Please list any surgeries you have had and include approximate dates of each.
_____
_____
_____
_____

9. Please list any medications that you are allergic to (and your reaction to the medication):
_____

Pregnancy History

10. Have you ever been pregnant? ( ) Yes ( ) No. If yes, please complete the rest of the pregnancy history:

In the table on the next page, where it says type of delivery, the choices are C-S for Cesarean delivery, SVD for spontaneous vaginal delivery, FVD for forceps-assisted vaginal delivery, SpAb for miscarriage, Eab for abortion, "tubal" for tubal or ectopic pregnancy, SB for stillbirth (which is any delivery of a baby after 20 weeks who died at or prior to delivery.)

Gestational age of your baby at the time of your due date is 40 weeks. If you delivered 2 weeks early, the gestational age at the time of your delivery would be 38 weeks.

Did you have any complications with your pregnancies or deliveries such as high blood pressure (HTN), gestational diabetes (GDM), pre-term labor (PTL), or infection postpartum? Did your baby have any problems after delivery that required special treatment or an extended stay in the hospital? ( )Yes ( ) No.

If yes, please write this in the chart below:

Date of Birth	Type of Delivery (SVD/C-S) (SpAb/Eab)	F/Male And Name	Birth Weight	Weeks Gestational Age at Delivery	Where Delivered (City/State)	Complications of Labor and/or Delivery
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						

Menstrual History

11. How old were you when you had your first period?_____ Were they regular (one per month right away)? Y/N
Were they painful from the first menstrual period? Y/N

What was the first day of your last (most recent) period: _____.
Do you currently have your period every month? ( ) Yes ( ) No
Interval (number of days from the **start** of one period until the **start** of the next period e.g. 24-35 days): _____

All women have different heaviness of their menstrual periods, some consider heavy flow to be 4 pads per day, some consider heavy flow to be 8 pads per day.
Total number of days of flow/bleeding: _____
_____ Days of heavy flow = _____pads / tampons per day
_____ Days of light flow = _____pads / tampons per day

Have you ever had any of the following? (Circle the ones that apply)

Gonorrhea / Chlamydia / Trichomonas / Syphilis / Herpes / Genital Warts / PID (Pelvic Inflammatory Disease)

12. Have you ever had a mammogram? ( ) Yes ( ) No If yes, give date of most recent _____

13. Have you ever had a pelvic (vaginal) exam? ( ) Yes ( ) No

14. Date of last Pap smear _____. Results: ( ) Normal ( ) Abnormal ( ) Unknown.
Who did your last Pap smear? _____

15. Have you ever had an abnormal pap smear where the physician advised you have a colposcopy or biopsy? Or have you ever had a biopsy, LEEP, conization, or freezing of your cervix? ( ) Yes ( ) No When?_____ By whom?_____
Were you told the abnormality was dysplasia or pre-cancer? What kind of treatment did you receive?
_____

16. Do you use feminine hygiene products (sprays, deodorants, suppositories, douches)? ( ) Yes ( ) No
If yes, how often? _____

Contraceptive History

17. Have you ever used any items or systems to keep from getting pregnant? ( ) Yes ( ) No
If yes, what method (s) have you used? *CHECK ALL THAT YOU HAVE EVER USED.*

( ) a. Withdrawal (pulling out)
( ) b. Oral (the pill)
( ) c. IUD (coil, cord, loop)
( ) d. Condom (rubber)
( ) e. Diaphragm
( ) f. Foam, Jelly, Cream
( ) g. Suppositories (Encare, etc)
( ) h. Contraceptive Sponge
( ) i. Rhythm (calendar)
( ) j. Natural Family Planning
( ) k. Injection (shot)
( ) l. I am sterile (tubes tied)
( ) m. Partner sterile
( ) n. Abstinence (saying no)
( ) o. Luck
( ) p. Other _____

What method(s) are you using now?_____ How long have you been using method(s)? _____

What method(s) do you want to use now?_____

18. Are you trying to get pregnant? ( ) Yes ( ) No If yes, for how long? _____

THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE:

_____

Signature ***Date***

You have my permission to contact me by e-mail periodically with Ob/Gyn Updates:

_____

Signature ***Date***

Update For the Year Following Completion of the Self-History Questionnaire :

I have reviewed the Self-History Questionnaire that I completed on the above date.

( ) I verify that nothing has changed to this date.

( ) There have been changes:

Refer to: _____

Signature _____Date _____

HIPAA Waiver

Occasionally, patients will have a spouse or family member call the doctor's office for them. It is against HIPAA rules and regulations to give any information to anyone else unless we have prior written consent to do so. Please give us the name, phone number, and relationship of anyone that you may have call us. And to whom you would like us to provide them your confidential health information. This permission can be revoked at any time with written notification. (Health Care Representative.)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____