OLATHE OBSTETRICS AND GYNECOLOGY, P.A.

DOUGLAS B. MACFARLANE, M.D., F.A.C.O.G.

DATE _____

NAME _____ MAIDEN NAME _____

MARITAL STATUS: □ S □ M □ D □ W DATE OF BIRTH_____

FAMILY HISTORY – PLEASE INDICATE ANY OF THE FOLLOWING THAT APPLY:

YES	NO		RELATIONSHIP
□	□	**CANCER**	_____
□	□	**HEART DISEASE**	_____
□	□	**KIDNEY DISEASE**	_____
□	□	**HIGH BLOOD PRESSURE**	_____
□	□	**BREAST DISEASE**	_____
□	□	**REACTION TO ANESTHESIA**	_____
□	□	**DIABETES**	_____
□	□	**THYROID DISEASE**	_____
□	□	**OSTEOPOROSIS**	_____
□	□	**ARTHRITIS**	_____

HAVE YOU EVER SMOKED? □ **YES** □ **NO**

	AMOUNT	AGE BEGAN	AGE STOPPED
CIGARETTES			
OTHER			

HAVE YOU CONSUMED ALCOHOL? □ **YES** □ **NO**

	DAILY	WEEKLY	MONTHLY	NEVER
PRESENTLY				
PAST				

HAVE YOU CONSUMED STREET DRUGS? □ **YES** □ **NO**

TYPE	AGE BEGAN	AGE STOPPED

ARE YOU PREGNANT? □ **YES** □ **NO** **ARE YOU PLANNING PREGNANCY?** □ **YES** □ **NO**

NUMBER OF LIVING CHILDREN _____ **AGES** _____

DO YOU USE SUNSCREEN? □ **YES** □ **NO** **SPF** _____ **IF NOT, WHY?** _____

PLEASE CONTINUE ON THE NEXT PAGE

HEALTH HISTORY:
PLEASE INDICATE ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH:

YES	NO			YES	NO		
☐	☐	ANEMIA	DATE_____	☐	☐	MENTAL DISORDERS	DATE_____
☐	☐	HEAVY MENSES	DATE_____	☐	☐	ULCER	DATE_____
☐	☐	PAIN WITH MENSES	DATE_____	☐	☐	HEARTBURN	DATE_____
☐	☐	CANCER	DATE_____	☐	☐	HIGH CHOLESTEROL	DATE_____
☐	☐	DIABETES	DATE_____	☐	☐	BOWEL ABNORMALITY	DATE_____
☐	☐	HEART TROUBLE	DATE_____	☐	☐	SKIN DISORDER	DATE_____
☐	☐	CHEST PAIN	DATE_____	☐	☐	GENITAL INFECTION	DATE_____
☐	☐	BLOOD TRANSFUSION	DATE_____	☐	☐	TB	DATE_____
☐	☐	CESAREAN SECTION	DATE_____	☐	☐	ASTHMA	DATE_____
☐	☐	ABNORMAL PAP	DATE_____	☐	☐	REACTION TO ANESTHESIA	DATE_____
☐	☐	FATIGUE	DATE_____	☐	☐	SEIZURES	DATE_____
☐	☐	SINUS PROBLEMS	DATE_____	☐	☐	WEIGHT GAIN	DATE_____
☐	☐	HIGH BLOOD PRESSURE	DATE_____	☐	☐	WEIGHT LOSS	DATE_____
☐	☐	URINARY PROBLEMS	DATE_____	☐	☐	HEPATITUS	DATE_____
☐	☐	THYROID DISORDER	DATE_____	☐	☐	BREAST LUMPS	DATE_____
☐	☐	JAUNDICE	DATE_____	☐	☐	OTHER_____	DATE_____

DRUG ALLERGIES:
TYPE OF DRUG_____ REACTION_____

TYPE OF DRUG_____ REACTION_____

TYPE OF DRUG_____ REACTION_____

TYPE OF DRUG_____ REACTION_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DOSAGE:

_____

_____

_____

_____

_____

OPERATIONS:
TYPE _____ DATE _____

TYPE _____ DATE _____

TYPE _____ DATE _____

TYPE _____ DATE _____

OTHER THAN THE COMMON COLD, HAVE YOU BEEN TREATED BY A PHYSICIAN WITHIN THE LAST FIVE (5) YEARS THAT IS NOT PREVIOUSLY INDICATED?

_____

_____

LIST ANY OTHER MEDICAL CONDITION THAT WE NEED TO BE AWARE OF:

_____

_____