OB/GYN OF FAIRFIELD COUNTY, LLC

Health History:

Last Name:_____First Name:_____ MI:_____

Primary Care Physician_____ Date_____

DOB:_____ Age:_____ Last PAP:_____ Last period_____

Medications: Please List:

_____

_____

_____

Allergies: Please List:

_____

_____

Past Medical/Surgical History (Ex. Endometriosis, Ovarian Cyst, hospitalizations

Illness: _____ Year _____

Illness: _____ Year _____

Illness: _____ Year _____

Family History : Please list serious illness in your immediate family:

_____

_____

_____

Social History:

Do you drink alcohol: Y N If so, how much _____

Do you or someone in your household smoke: Y N If so, how much _____

Living Arrangements: Husband Children Other_____

Education Level: High School College Grad School _____

Continue on other side