## **REITER, HILL, & JOHNSON**

## **OB** MEDICAL UPDATE

1. Picase ☑ any of the below condition(s) that you have or have had in the past:         □Cancer       □Headaches       □Bowel Disease       □Gynecological Infections         □HIV/AIDS       □Asthma       □Heart Disease       □Group B Strep Carrier         □Diabetes       □Hepatitis       □Kidney Disease       □Von Willebrands/Bleeding Disorder         □Epilepsy       □High Blood Pressure       □Eating Disorder       □Recurrent Urinary Tract Infections         □Herpes       □Depression       □LEEP/Cone Biopsy       □Incompetent Cervix/Previous D & C's         □Anemia       □Thyroid Disorder       □Clotting Disorder       □Arthritis/Lupus/Connective Tissue Disease         Please describe:	Patient Name:						
HIV/AIDS       Asthma       Heart Disease       Group B Strep Carrier         Diabetes       HHepatitis       Kidney Disease       Von Willebrands/Bleeding Disorder         Epilepsy       Htigh Blood Pressure       Eating Disorder       Recurrent Urinary Tract Infections         Herpes       Depression       LEEP/Cone Biopsy       Incompetent Cervix/Previous D & C's         Anemia       Thyroid Disorder       Clotting Disorder       Arthritis/Lupus/Connective Tissue Disease         Please describe:	<b>1.</b> Please I any of the below condition(s) that you have or have had in the past:						
Diabetes       Hepatitis       Kidney Disease       Von Willebrands/Bleeding Disorder         Epilepsy       High Blood Pressure       Eating Disorder       Recurrent Urinary Tract Infections         Herpes       Depression       LEEP/Cone Biopsy       Incompetent Cervix/Previous D & C's         Anemia       Thyroid Disorder       Clotting Disorder       Arctritis/Lupus/Connective Tissue Disease         Please describe:	Cancer	Cancer Headaches Bowel Disease Gynecological Infe			ions		
Epilepsy       High Blood Pressure       Eating Disorder       Recurrent Urinary Tract Infections         Herpes       Depression       LEEP/Cone Biopsy       Incompetent Cervix/Previous D & C's         Anemia       Thyroid Disorder       Clotting Disorder       Arthritis/Lupus/Connective Tissue Disease         Please describe:	HIV/AIDS	IIV/AIDS Asthma Heart Disease Group B Strep Carr		er			
Herpes       Depression       LEEP/Cone Biopsy       Incompetent Cervix/Previous D & C's         Anemia       Thyroid Disorder       Clotting Disorder       Arthritis/Lupus/Connective Tissue Disease         Please describe:	Diabetes	Diabetes Hepatitis Kidney Disease Von Willebrands/Bl		eding Disor	der		
Herpes       Depression       LEEP/Cone Biopsy       Incompetent Cervix/Previous D & C's         Anemia       Thyroid Disorder       Clotting Disorder       Arthritis/Lupus/Connective Tissue Disease         Please describe:	<b>□</b> Epilepsy	pilepsy  ☐ High Blood Pressure  ☐ Eating Disorder  ☐ Recurrent Urinary		Recurrent Urinary Tr	act Infectio	ns	
Please describe:	Herpes	Image: Incomposition         Image: Incomposition		Previous D	& C's		
2. Please list any prior surgeries that you have had:		□ Thyroid Disorder	Clotting Disorder	Arthritis/Lupus/Connective Tissue Disease		ue Disease	
2. Please list any prior surgeries that you have had:	Please describe						
3. Are you allergic to any medications?       I YES       NO         If yes, please list medicine and reaction:       I YES       NO         4. Have you taken any medications (prescriptions, over-the-counter or herbal) since your last menstrual period?       YES       NO         1f yes, please list:       I YES       NO         5. Do you smoke cigarettes?       I YES       NO         6. Do you drink alcoholic beverages?       I YES       NO         7. Do you use any recreational drugs?       I YES       NO         8. Have you been exposed to chemicals or radiation (i.e. X-rays) since your last menstrual period?       I YES       NO         9. Do you or any family member have a history of problems with anesthesia?       I YES       I NO         10. Do you have any religious objections to any form of medical treatment including blood transfusions?       I YES       I NO         11. Do you own or take care of cats?       I YES       I NO         12. Do you have any family members with a history of blood clotting disorders?       I YES       I NO							
3. Are you allergic to any medications?       I YES       NO         If yes, please list medicine and reaction:       I YES       NO         4. Have you taken any medications (prescriptions, over-the-counter or herbal) since your last menstrual period?       YES       NO         5. Do you smoke cigarettes?       I YES       NO         6. Do you drink alcoholic beverages?       I YES       NO         7. Do you use any recreational drugs?       I YES       NO         8. Have you been exposed to chemicals or radiation (i.e. X-rays) since your last menstrual period?       I YES       NO         9. Do you or any family member have a history of problems with anesthesia?       I YES       I NO         10. Do you have any religious objections to any form of medical treatment including blood transfusions?       I YES       I NO         11. Do you own or take care of cats?       I YES       I NO         12. Do you have any family members with a history of blood clotting disorders?       I YES       I NO	2 Please list any prior surgeries that you have had						
If yes, please list medicine and reaction:							
If yes, please list medicine and reaction:	2 Are you allorgin to any mediantions?						
4. Have you taken any medications (prescriptions, over-the-counter or herbal) since your last menstrual period?       □ YES       □ NO         If yes, please list:       □ YES       □ NO         5. Do you smoke cigarettes?       □ YES       □ NO         6. Do you drink alcoholic beverages?       □ YES       □ NO         7. Do you use any recreational drugs?       □ YES       □ NO         8. Have you been exposed to chemicals or radiation (i.e. X-rays) since your last menstrual period?       □ YES       □ NO         9. Do you or any family member have a history of problems with anesthesia?       □ YES       □ NO         10. Do you have any religious objections to any form of medical treatment including blood transfusions?       □ YES       □ NO         11. Do you own or take care of cats?       □ YES       □ NO         12. Do you have any family members with a history of blood clotting disorders?       □ YES       □ NO						LI NO	
since your last menstrual period?       IYES       NO         If yes, please list:       IYES       NO         5. Do you smoke cigarettes?       IYES       NO         6. Do you drink alcoholic beverages?       IYES       NO         7. Do you use any recreational drugs?       IYES       NO         8. Have you been exposed to chemicals or radiation (i.e. X-rays) since your last menstrual period?       IYES       NO         9. Do you or any family member have a history of problems with anesthesia?       IYES       NO         10. Do you have any religious objections to any form of medical treatment including blood transfusions?       IYES       NO         11. Do you own or take care of cats?       IYES       NO         12. Do you have any family members with a history of blood clotting disorders?       IYES       NO					-		
If yes, please list:						□ NO	
6. Do you drink alcoholic beverages?       □ YES       □ NO         7. Do you use any recreational drugs?       □ YES       □ NO         8. Have you been exposed to chemicals or radiation (i.e. X-rays) since your last menstrual period?       □ YES       □ NO         9. Do you or any family member have a history of problems with anesthesia?       □ YES       □ NO         10. Do you have any religious objections to any form of medical treatment including blood transfusions?       □ YES       □ NO         11. Do you own or take care of cats?       □ YES       □ NO         12. Do you have any family members with a history of blood clotting disorders?       □ YES       □ NO	• •						
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menstrual period?       □ YES       □ NO         9. Do you or any family member have a history of problems with anesthesia?       □ YES       □ NO         If yes, please describe:	7. Do you use any recreational drugs?				LI YES		
If yes, please describe:					□ YES	□ NO	
10. Do you have any religious objections to any form of medical treatment including blood transfusions?          □ YES         □ NO         □ NO         □ YES         □ NO         □ NO         □ YES         □ NO         □ NO         □ YES         □ NO         □ NO         □ NO         □ YES         □ NO         □					□ YES	□ NO	
including blood transfusions?          □ YES         □ NO         □ NO         □ YES         □ NO         □ YES         □ NO         □ NO         □ YES         □ NO         □ NO         □ YES         □ NO         □ NO         □ NO         □ YES         □ NO         □ NO							
12. Do you have any family members with a history of blood clotting disorders?       □ YES       □ NO         12. Do you have any family members with a history of blood clotting disorders?       □ YES       □ NO					□ YES		
	11. Do you own or take care of cats?				<b>VES</b>		
13. Do you work with elementary or preschool children?          □ YES         □ NO         □	12. Do you have any family members with a history of blood clotting disorders?				□ YES	□ NO	
	13. Do you work with elementary or preschool children?						