HILO OBSTETRICS & GYNECOLOGY – QUYEN TRAN, M.D.

Name_____ DOB _____ Date_____

PCP _____ Preferred pharmacy_____ Insurance _____

Marital status _____Occupation _____

Pregnancy history: #of pregnancy: ___ #preterm delivery: ___ #miscarriage/abortion: ___ #living children:___.

Are you sexually active? ☐ Yes ☐ No ☐ Never Current contraceptive method: _____

What other methods have you used in the past? (check all that apply):

☐ Condoms ☐ Pills ☐ Ring ☐ Patch ☐ Depo ☐ IUD ☐ Implanon ☐ Tubes tied ☐ Vasectomy

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List allergies and reaction: _____ ☐ **NKDA**

Smoking? ____ How much now or in the past? _____ How many year? ___ How long have you quit?___

How much alcohol/week? _____ List any illegal drugs use _____

Please circle: any history of physical/emotional/sexual/verbal abuse? ☐ None Are you safe? ☐ Yes ☐ No

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Please list all major medical problems in your family and put in parenthesis who it affected: _____

_____

_____

Please list all medical problems:	All surgeries in the past:	Medications, dosage, and frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____