Derakhsh Fozouni M.D. Ob/Gyn & Assoc. AMC

Patient History Form

Obstetric

Name_____

Birthdate _____ Age _____

The reason for your visit?_____

Have you seen another physician for this issue? _____

How long have you known about this pregnancy?_____

Have you been pregnant before? _____

Do you have any allergies to medicine or anesthesia?_____

If yes, what reaction did you have? _____

Do you currently have any medical problems?_____

How long have you had this/these medical issue/s?_____

If yes, What medications do you take for it/them?

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Have you ever had a blood Transfusion? Yes or No

If YES, how many units & why? _____

Have you had any surgeries in the past? Yes or No

Name of surgery _____ what year_____

Name of surgery _____ what year_____

Name of surgery _____ what year_____

Name of surgery _____ what year_____

Have you ever been hospitalized ? Yes or No

If yes, please explain_____

_____

How many times have you been pregnant (including this one) _____

How many children do you have?_____

How many live births have you had ?_____

How many spontaneous miscarriages have you had?_____

How many elective abortions have you had?_____

Have you breast fed previously? Yes No If yes, how long have you breastfed for?_____

Are you breastfeeding now? Yes No If yes, how long have you been breastfeeding? _____

Date of Birth Of your children	When was your baby supposed to be born	Your baby's gender Boy or girl	Weight	Vaginal Or C-Section	Did you get an epidural?	Did you have diabetes? High blood pressure? Pre-eclampsia? Seizure or other complications?	Where was the baby born?

Have you had a baby born with birth defects? Yes NO If yes, what defect?_____

Does your partner have any other kids born with birth defects? Yes NO

If yes, what defect?_____

The age you had your very first period _____

Are your periods every month? Yes or No

How many days between periods?_____ How many days do your menses last?_____

Date of your last PAP SMEAR _____

Have you ever had an abnormal PAP smear? Yes or No

Date of your last mammogram _____

Do you perform self breast examination? Yes Or No

First day of your last period _____

What is the birth control you're using right now?_____

Have you ever had a sexually transmitted infection such as the following:(please circle all that apply) Chlamydia, Gonorrhea, Syphilis, HIV, Hepatitis B or C, Herpes, Trichomonas?

Are you Married Single Divorced Separated

Do you work? Yes No If yes, What do you do?_____

Do you smoke weed or Tobacco ? Yes No

If yes, what & how much per day?_____

How long have you been smoking?_____

If you quit, when did you quit smoking? _____

Do you VAPE? Yes No If Yes, What do you vape? Tobacco WEED Others(please specify)_____

Do you drink alcoholic beverages? _____ how much per day ?_____

what type of drink? _____

Do you use illicit/illegal drugs?_____

What is your highest educational level?_____

Family History Complete the information about the health of your family members

Mark with a check mark (✓) all the medical problems that your blood relatives have

Disease	Relation to you
Arthritis/Gout	
Asthma	
Breast Cancer? Ovarian cancer?	
cancer(Other)	
Drug addiction	
Diabetes	
Cardiac issues, strokes,	
High blood pressure	
Kidney disorders	
Tuberculosis	
other	

Will you accept blood transfusion if absolutely necessary? Yes or No

What Ethnicity would you ascribe to yourself? (Please write)_____

Will you be or are you interested in other services that we offer?(circle all that apply, these are offered at our adjacent office, Lotus Aesthetica)

3D ultrasounds of the baby and gender reveal ultrasounds? ($150 for package and $60 per session)

Laser hair removal (a permanent procedure typically done every 4-6 weeks for 4-6 treatments)

Cellulite removal (procedure typically done every week for 4-6 treatments)

Stretch marks (procedure typically done every 4-6 weeks for 4-6 treatments)

Wrinkles (procedure typically done every 4-6 weeks for 4-6 treatments)

Improvement of surgical and acne scars (procedure typically done every 4-6 weeks for 4-8 treatments)

Melasma, sun spots and/or age spots (procedure typically done every 2-4 weeks for 4-8 treatments)

Vaginal and vulvar rejuvenation (procedure typically done every 4 weeks for 3 treatments)

Body sculpting and permanent fat reduction (procedure typically done every 4-6 weeks for 2-4 treatments)

Flaccid and loose/saggy skin improvement (procedure typically done every week for 4-6 treatments)