

**NEW PATIENT HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Pharmacy address \_\_\_\_\_ Phone \_\_\_\_\_

Reason for today's visit \_\_\_\_\_  
\_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

**OB HISTORY**

|                  |        |             |        |                 |        |
|------------------|--------|-------------|--------|-----------------|--------|
|                  | NUMBER |             | NUMBER |                 | NUMBER |
| Pregnancies      | _____  | abortions   | _____  | miscarriages    | _____  |
| Premature births | _____  | live births | _____  | living children | _____  |

|            |                  |                 |              |            |
|------------|------------------|-----------------|--------------|------------|
| BIRTH DATE | TYPE OF DELIVERY | WEEKS PREGNANCY | BIRTH WEIGHT | BABY'S SEX |
| _____      | _____            | _____           | _____        | _____      |
| _____      | _____            | _____           | _____        | _____      |
| _____      | _____            | _____           | _____        | _____      |

Pregnancy complications:      diabetes      high blood pressure      other \_\_\_\_\_

History of depression before or after pregnancy?      Yes      No      \_\_\_\_\_

**GYN HISTORY**

How old were you when you had your first period? \_\_\_\_\_

Are your cycles regular/monthly?      Yes      No

How many days does your period last? \_\_\_\_\_

If in menopause, at what age did it occur? \_\_\_\_\_

Years of hormone replacement therapy? \_\_\_\_\_

Are you currently sexually active?      Yes      No

    If not, have you ever been sexually active?      Yes      No

Do you currently have a partner?      Yes      No      Partner's gender \_\_\_\_\_

How long have you been in this relationship? \_\_\_\_\_

How many lifetime sexual partners have you had? \_\_\_\_\_

At what age was your first intercourse? \_\_\_\_\_

Have you ever been sexually abused, threatened or hurt by anyone? \_\_\_\_\_

Are you experiencing any sexual problems? \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_

Have you had any abnormal pap smears? Yes No when? \_\_\_\_\_

Have you been told you have HPV? Yes No when? \_\_\_\_\_

Have you had any treatments for abnormal pap smears? Yes No repeat pap colposcopy biopsy

Have you received HPV vaccine? Yes No date \_\_\_\_\_

Have you ever had ovarian cysts? Yes No

Have you been told you have fibroids of the uterus? Yes No

Have you ever been treated for any sexually transmitted infections? Yes No

Gonorrhea Chlamydia Syphilis Herpes Condyloma PID

Have you ever been tested for HIV? YES NO Date of last test? \_\_\_\_\_ Result? Neg Pos

Current birth control

None Timing Condoms Diaphragm Birth control pills Patch  
Implants Depo Provera IUD Tubal ligation Vasectomy Ring

Past birth control

None Timing Condoms Diaphragm Birth control pills Patch  
Implants Depo Provera IUD Tubal ligation Vasectomy Ring

Have you ever had a yeast infection? Yes No Chronic? Yes No

Have you ever been treated for a vaginal bacterial infection (bacterial vaginosis)? Yes No Chronic? Yes No

Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in your urine? Yes No

If yes, please explain \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

Have you had any abnormal mammograms? Yes No \_\_\_\_\_

Have you had any breast biopsies? Yes No If yes, result \_\_\_\_\_

Do you do breast self examination? Yes No

**HEALTH MAINTENANCE**

Procedure date results

Last bone density \_\_\_\_\_

Last cholesterol \_\_\_\_\_

Last colonoscopy \_\_\_\_\_

**MEDICAL HISTORY**

|                            |     |    |       |
|----------------------------|-----|----|-------|
| Arthritis                  | yes | no | _____ |
| Asthma                     | yes | no | _____ |
| Chronic lung disease       | yes | no | _____ |
| Cancer                     | yes | no | _____ |
| Diabetes                   | yes | no | _____ |
| Eye disease                | yes | no | _____ |
| Heart disease              | yes | no | _____ |
| Hypertension               | yes | no | _____ |
| Kidney disease             | yes | no | _____ |
| Liver disease              | yes | no | _____ |
| Psychiatric disorder       | yes | no | _____ |
| Seizures/epilepsy          | yes | no | _____ |
| Stomach/intestinal disease | yes | no | _____ |
| Stroke                     | yes | no | _____ |
| Thyroid disease            | yes | no | _____ |
| Other                      |     |    | _____ |

**SURGICAL HISTORY**

List any surgeries you have had and the approximate date

Example: tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery/biopsy, laparoscopy

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had a blood transfusion?                      Yes      No      if yes, when \_\_\_\_\_

**FAMILY HISTORY**                      **list any MEDICAL CONDITIONS of your relatives**

Mother                      living/deceased \_\_\_\_\_

Father                      living/deceased \_\_\_\_\_

Siblings                      \_\_\_\_\_

|                     |     |    | Relationship to you |
|---------------------|-----|----|---------------------|
| Diabetes            | yes | no | _____               |
| Hypertension        | yes | no | _____               |
| Thyroid disease     | yes | no | _____               |
| Cancer              |     |    |                     |
| Breast              | yes | no | _____               |
| Ovarian             | yes | no | _____               |
| Colon               | yes | no | _____               |
| Other               |     |    | _____               |
| Psychiatric illness | yes | no | _____               |
| Osteoporosis        | yes | no | _____               |
| Other               | yes | no | _____               |

**SOCIAL HISTORY**

Occupation \_\_\_\_\_

Marital status      single                      married                      separated                      divorced                      widowed

Children \_\_\_\_\_

Pets \_\_\_\_\_

Tobacco              yes      no      quit      #cigarettes/day \_\_\_\_\_              #years \_\_\_\_\_

Alcohol              yes      no      quit      #drinks per day/week \_\_\_\_\_              type \_\_\_\_\_

Drugs              yes      no      quit      \_\_\_\_\_

Exercise              yes      no              #times/week \_\_\_\_\_              type \_\_\_\_\_

Health care proxy      yes      no

Seat belt use              yes      no

**MEDICATIONS** (including over the counter medications and supplements)

| Name  | Dose  |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

List any medications or foods that you are **ALLERGIC** to (and the reaction):

\_\_\_\_\_

\_\_\_\_\_

**REVIEW OF SYSTEMS****Please circle all that are applicable (within the last 6-12 months)****CONSTITUTIONAL**Fever  
Chills Negativefeeling poorly  
feeling tiredrecent weight gain  
recent weight loss**EYES**Eye Pain  
Wearing glasses Negativespots before eyes  
vision changesdry eyes  
itchy eyes**EAR/NOSE/THROAT**Earaches  
Loss of hearing Negativenose bleeds  
sinus problemssore throat  
dental problems**CARDIOVASCULAR**Chest pain  
Palpitations Negativeheart rate is fast  
heart rate is slow

leg swelling (edema)

**RESPIRATORY**Shortness of breath  
Wheezing Negativecough  
dyspnea (shortness of breath) on exertionshortness of breath with lying flat (orthopnea)  
respiratory distress in sleep (PND)**GASTROINTESTINAL**Abdominal pain  
Vomiting  
Nausea Negativeconstipation  
diarrhea  
early satietyheartburn  
black stool (melena)  
maroon colored stool (hematochezia)**OB/GYN GU**Frequency  
Nocturia  
Dysuria Negativeblood in urine  
cloudy urine  
odor in urineincomplete emptying of bladder  
stress incontinence  
urge incontinence**OB/GYN**Abnormal bleeding  
Irregular menses  
Pain with menses  
Pain with intercourse  
Anorgasmia Negativevulvar itching  
midcycle bleeding  
post coital bleeding  
vulvar pain  
decreased libidovaginal itching  
pelvic pain  
vaginal dryness  
vaginal discharge  
vaginal odor**MUSCULOSKELETAL**

Arthralgia (joint pain)

 Negativejoint swelling  
joint stiffnesslimb pain  
limb swelling**INTEGUMENTARY (SKIN)**Acne  
Breast discharge Negativeitching  
change in a molebreast pain  
breast lump**NEUROLOGICAL**Confused  
Memory problems Negativedizziness  
headaches/migraineslimb weakness  
difficulty walking**PSYCHIATRIC**Suicidal  
Sleep disturbances Negativeanxiety  
depressionchange in personality  
emotional problems**ENDOCRINE**Hair loss  
Hot flashes  
Heat/cold intolerance Negativemuscle weakness  
deepening of the voicefeeling weak  
dry skin**HEMATOLOGY/IMMUNOLOGY**Easy bleeding  
seasonal allergies Negative

swollen glands

easy bruising