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 ☐ Negative
- ☐ Fever
- ☐ Chills
- ☐ feeling poorly
- ☐ feeling tired
- ☐ recent weight gain
- ☐ recent weight loss

EYES ☐ Negative
- ☐ Eye Pain
- ☐ Wearing glasses
- ☐ spots before eyes
- ☐ vision changes
- ☐ dry eyes
- ☐ itchy eyes

EAR/NOSE/THROAT ☐ Negative
- ☐ Earaches
- ☐ Loss of hearing
- ☐ nose bleeds
- ☐ sinus problems
- ☐ sore throat
- ☐ dental problems

CARDIOVASCULAR ☐ Negative
- ☐ Chest pain
- ☐ Palpitations
- ☐ heart rate is fast
- ☐ heart rate is slow
- ☐ leg swelling (edema)

RESPIRATORY ☐ Negative
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ cough
- ☐ dyspnea (shortness of breath) on exertion
- ☐ shortness of breath with lying flat (orthopnea)
- ☐ respiratory distress in sleep (PND)

GASTROINTESTINAL ☐ Negative
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Nausea
- ☐ constipation
- ☐ diarrhea
- ☐ early satiety
- ☐ heartburn
- ☐ black stool (melena)
- ☐ maroon colored stool (hematochezia)

OB/GYN GU ☐ Negative
- ☐ Frequency
- ☐ Nocturia
- ☐ Dysuria
- ☐ blood in urine
- ☐ cloudy urine
- ☐ odor in urine
- ☐ incomplete emptying of bladder
- ☐ stress incontinence
- ☐ urge incontinence

OB/GYN ☐ Negative
- ☐ Abnormal bleeding
- ☐ Irregular menses
- ☐ Pain with menses
- ☐ Pain with intercourse
- ☐ Anorgasmia
- ☐ vulvar itching
- ☐ midcycle bleeding
- ☐ post coital bleeding
- ☐ vulvar pain
- ☐ decreased libido
- ☐ vaginal itching
- ☐ pelvic pain
- ☐ vaginal dryness
- ☐ vaginal discharge
- ☐ vaginal odor

MUSCULOSKELETAL ☐ Negative
- ☐ Arthralgia (joint pain)
- ☐ joint swelling
- ☐ joint stiffness
- ☐ limb pain
- ☐ limb swelling

INTEGUMENTARY (SKIN) ☐ Negative
- ☐ Acne
- ☐ Breast discharge
- ☐ itching
- ☐ change in a mole
- ☐ breast pain
- ☐ breast lump

NEUROLOGICAL ☐ Negative
- ☐ Confused
- ☐ Memory problems
- ☐ dizziness
- ☐ headaches/migraines
- ☐ limb weakness
- ☐ difficulty walking

PSYCHIATRIC ☐ Negative
- ☐ Suicidal
- ☐ Sleep disturbances
- ☐ anxiety
- ☐ depression
- ☐ change in personality
- ☐ emotional problems

ENDOCRINE ☐ Negative
- ☐ Hair loss
- ☐ Hot flashes
- ☐ Heat/cold intolerance
- ☐ muscle weakness
- ☐ deepening of the voice
- ☐ feeling weak
- ☐ dry skin

HEMATOLOGY/IMMUNOLOGY ☐ Negative
- ☐ Easy bleeding
- ☐ seasonal allergies
- ☐ swollen glands
- ☐ easy bruising