

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)

RESPIRATORYShortness 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