



New Patient History Form

(Less Than 18 Years of Age)
Obstetrics & Gynecology

Name _____ Age _____ Date of Birth _____
first middle last

Form Completed By _____ Relationship To Patient _____

Are you in school? ☐ Yes ☐ No If yes, where? _____

Referred to our office by: _____

What is the purpose of your visit? _____

How long have you had this problem? _____

Have you consulted anyone else? ☐ Yes ☐ No Who? _____

Describe any previous testing and/or treatment: _____

Please list all medications you are currently taking. Please include over the counter medications and herbal supplements. _____

Please list all allergies to medications, latex, iodine, foods: _____

GYNECOLOGY REVIEW

Have you had a period? ☐ Yes ☐ No

Date of last normal period: _____ Age when your periods first started: _____

How often does your period come? Every _____ days

How many days do you usually bleed? _____

I use _____ pads and/or _____ tampons on my heaviest days
How many? How many?

Do you have significant pain with your periods? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Do you have to take any pain relievers during your period? ☐ Yes ☐ No

If yes, what do you usually take? _____ How much? _____

Do you have PMS? ☐ Yes ☐ No _____

Do you use birth control? ☐ Yes ☐ No If so, what kind? _____

Did you receive the HPV Vaccine (Gardasil®)? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Patient Name _____ DOB _____

OTHER GYNECOLOGY COMPLAINTS

Do you have abnormal vaginal discharge? ☐ Yes ☐ No Describe: _____

Have you used medication for the discharge? ☐ Yes ☐ No Medication used: _____

Have you been treated in the past for a vaginal infection? ☐ Yes ☐ No

If yes, with what medicines? _____

What type of vaginal infection was it? _____

Do you have a history of physical/sexual/emotional abuse? ☐ Yes ☐ No

If yes, did you undergo counseling/treatment? ☐ Yes ☐ No

Is this something you would like to talk about? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No Do you feel safe at school? ☐ Yes ☐ No

Do you currently have problems with urination? ☐ Yes ☐ No If yes, please describe: _____

Any significant breast changes that you have noticed? ☐ Yes ☐ No

Do you have: breast lumps nipple discharge breast tenderness

SOCIAL HISTORY

Who lives with you in your house? _____

Have you ever smoked? ☐ Yes ☐ No If yes, please describe: _____

Have you ever tried alcohol? ☐ Yes ☐ No If yes, please describe: _____

Have you ever tried drugs? ☐ Yes ☐ No If yes, please describe: _____

SURGERIES AND HOSPITALIZATIONS (Use a separate piece of paper if more space is needed)

Surgery/Hospitalization	Date	Reason/Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WOULD YOU ACCEPT A BLOOD TRANSFUSION IF NEEDED IN CASE OF EMERGENCY? ☐ YES ☐ NO

Patient Name

DOB

FAMILY HISTORY

Relationship	Age	Age at Death	Medical Conditions
Father			
Mother			
Brother			
Brother			
Sister			
Sister			

Does anyone in your family have Breast Cancer? ☐ Yes ☐ No Who? _____

Does anyone in your family have Ovarian Cancer? ☐ Yes ☐ No Who? _____

Does anyone in your family have Colon Cancer? ☐ Yes ☐ No Who? _____

Does anyone in your family have Osteoporosis ? ☐ Yes ☐ No Who? _____

Does anyone in your family have DVT or PE history? ☐ Yes ☐ No Who? _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

☐ High Blood Pressure

☐ Diabetes

☐ Kidney stones

☐ Lung Disease/COPD

☐ Heart Disease/heart attack

☐ Stroke

☐ Epilepsy/Seizures

☐ Asthma

☐ Deep Vein Thrombosis/pulmonary embolus

☐ Bleeding disorder (Von Willebrand/Hemophilia)

☐ Cancer Type: _____

Hepatitis ☐ A ☐ B ☐ C

☐ Thyroid Disease: _____

☐ HIV/AIDS

☐ Osteoporosis/osteopenia: _____

☐ GERD/hiatal hernia

☐ Lupus/Rheumatoid Arthritis/Sjogren's

☐ Depression or ☐ Anxiety

☐ Multiple Sclerosis

☐ Kidney Disease:

☐ Migraines:

☐ Other:

☐ Other:

☐ Other

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

Provider signature: Reviewed with patient: _____ Date: _____