



New Patient History Form

(Age 18 and over)

Obstetrics & Gynecology

Name _____ Age _____ Date of Birth _____
first middle last

Occupation _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred to our office by: _____

What is the purpose of your visit? _____

If you have a specific problem, please describe briefly: _____

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

Last Pap Smear: _____ Last Mammogram: _____ Last Bone Density: _____

Did you receive HPV Vaccine Series (Gardasil®)? 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 bleed or spot after sex? ☐ Yes ☐ No

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

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

Patient Name _____ Date of Birth _____

What form of birth control do you use?

☐ Birth control pills – Name: _____ How many years? _____

☐ IUD Type: _____ Date of insertion: _____

☐ Vasectomy ☐ Nexplanon / Date of insertion: _____

☐ Rhythm/Natural Family Planning ☐ Condoms/Foam/Suppositories

☐ Tubal Ligation ☐ Menopause

☐ Hysterectomy ☐ Patch/Vaginal Ring

☐ Other: _____

Have you reached Menopause? ☐ Yes ☐ No Age of onset: _____

Do you have hot flashes? ☐ Yes ☐ No Night sweats? ☐ Yes ☐ No

Vaginal dryness/painful intercourse? ☐ Yes ☐ No Trouble sleeping? ☐ Yes ☐ No

Have you taken hormone replacement therapy? ☐ Yes ☐ No

Medication taken _____

Duration of treatment? _____ Reason for discontinuation? _____

Herbal or natural supplements _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No What year? _____

Describe any treatment/follow-up: _____

Do you have a 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

☐ Yeast ☐ Chlamydia ☐ HPV/genital warts ☐ Trichomonas

☐ Gonorrhea ☐ Herpes/HSV virus ☐ Syphilis ☐ Bacterial/BV

☐ Pelvic Inflammatory Disease

Do you have pain during or after intercourse on a regular basis? ☐ Yes ☐ No

Do you have any concerns with sexual function/desire? ☐ Yes ☐ No

Do you have concerns with PMS? ☐ Yes ☐ No _____

Do you perform monthly breast self-exams? ☐ Yes ☐ No

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

Do you have: ☐ breast lumps ☐ nipple discharge ☐ breast tenderness

Patient Name _____

Date of Birth _____

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 (DVT or PE)

☐ Thyroid Disease: _____

☐ Depression or ☐ Anxiety

☐ Osteoporosis/osteopenia: _____

☐ GERD/hiatal hernia

☐ Lupus/Rheumatoid Arthritis/Sjogren's

☐ HIV/AIDS

☐ Multiple Sclerosis

☐ Kidney Disease: _____

☐ Migraine Disorder: _____

☐ Hepatitis ☐ A ☐ B ☐ C

☐ Bleeding disorder (Von Willebrand/Hemophilia)

☐ Cancer Type:

☐ Other _____

SOCIAL HISTORY

Do you consume caffeine daily? ☐ Yes ☐ No Servings/day _____

Do you drink alcohol on a regular basis? ☐ Yes ☐ No Drinks/week _____

Do you smoke? ☐ Yes ☐ No Packs/day _____

Have you smoked cigarettes in the past? ☐ Yes ☐ No When did you quit? _____

Do you use drugs on a regular basis? ☐ Yes ☐ No

Type and how much? _____

Have you used IV drugs in the past? ☐ Yes ☐ No

Do you think yourself as: *(Response to this question is optional)*

☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Something else ☐ Don't know

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

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OBSTETRICAL HISTORY

Please list pregnancies, miscarriages, and terminations from past to current:

Date	Length of pregnancy	D&C	Vaginal / C-Section	Girl/Boy	Weight	Complications

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

FAMILY HISTORY

Relationship	Age	Age at Death	Medical conditions
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Spouse			

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? _____

Patient Name _____ Date of Birth _____

Do you have concerns regarding your bladder? ___Yes ___ No If yes, answer the following questions:

Do you currently have:

___ Burning with urination

___ Blood in your urine

___ Frequency

___ Urgency

Do you leak urine when you cough/laugh/exercise/sneeze/have sex? ☐ Yes ☐ No

How many times a day do you leak? _____

If you leak on a regular basis, do you leak small or large amounts? _____

Do you have to wear a pad regularly because of your leakage? ☐ Yes ☐ No

How many pads do you use in 1 day? _____

How many times a night do you get up to urinate? _____

If you need to urinate, can you make it to the bathroom or do you leak on the way? _____

Do you feel like you can completely empty your bladder? ☐ Yes ☐ No

Do you have to apply pressure to your bladder or change positions to empty your bladder? ☐ Yes ☐ No

Do you ever have to apply pressure to your rectum to have a bowel movement? ☐ Yes ☐ No

Have you had a history of Urinary tract infections? ☐ Yes ☐ No

How many in the past year? _____

Have you ever seen a Urologist? ☐ Yes ☐ No

Have you ever had bladder surgery or treatment? ☐ Yes ☐ No If yes, explain below.

Explain _____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

Provider signature: Reviewed with patient: _____ Date: _____