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: _____