The Women's Health Group

New Patient History Form

(Less Than 13 Years of Age)

Obstetrics & Gynecology

Name_____ Age_____ Date_____
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 *If yes, complete below. If no, skip to* ***OTHER GYNECOLOGY COMPLAINTS***

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?_____

Patient Name_____ **DOB**_____

OTHER GYNECOLOGY COMPLAINTS

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

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

FAMILY HISTORY

Relationship	Age	Age at Death	Medical Conditions
Mother			

Patient Name_____ **DOB**_____

Relationship	Age	Age at Death	Medical Conditions
Father			
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 or Osteopenia? ☐ Yes ☐ No Who?_____

Does anyone in your family have problems with blood clots? ☐ Yes ☐ No Who?_____

PAST MEDICAL HISTORY

Have you ever had any of the following?

☐ Hypertension
☐ Diabetes
☐ Kidney disease/stones
☐ Lung Disease/COPD
☐ Heart Disease/heart attack
☐ Stroke
☐ Epilepsy/Seizures
☐ Asthma
☐ Blood clot/DVT/pulmonary embolus
☐ Bleeding disorder (Von Willebrands/Hemophilia)
☐ Cancer Type: _____
☐ Hepatitis ☐ A ☐ B ☐ C
☐ HIV/AIDS
☐ Hypothyroid/Hyperthyroid
☐ Anemia
☐ Osteoporosis/osteopenia
☐ GERD/hiatal hernia
☐ Lupus/Rheumatoid Arthritis/Sjogren's
☐ Depression/Anxiety
☐ Multiple Sclerosis
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed with patient_____Date_____