New Patient History Form
Obstetrics & Gynecology
Ver 20220804

Name: _____ Date: _____
First Middle Last

Age: _____ Occupation: _____

Referred to our office by: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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: _____
_____
_____
_____

Patient Name: _____ DOB: _____

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

Gynecology Review

Last Pap Smear: _____ Last Mammogram: _____
Last Bone Density: _____ Date of last normal period: _____
Age when your period 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 bleed or spot after sex? ☐ Yes ☐ No
Do you bleed or spot between periods? ☐ Yes ☐ No
Do you have significant pain with your periods? ☐ Yes ☐ No
Do you have to take pain relievers during your period? ☐ Yes ☐ No
If yes, what do you usually take? _____
_____
How much? _____

What form of birth control do you use?

☐ Birth control pills Name: _____ How many years:_____
☐ IUD Type: _____ Date of Insertion: _____
☐ Vasectomy ☐ Diaphragm
☐ Hysterectomy ☐ Menopause
☐ Tubal Litigation ☐ Not sexually active
☐ Rhythm/Natural Family Planning ☐ Condoms/Foam/Suppositories
Other: _____

Patient Name: _____ DOB: _____

Past Medical History

Have you ever been diagnosed with any of the following?

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

Have you ever been diagnosed with any of the following?

☐ Heart disease/Heart attack ☐ Cancer Type: _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

Have you reached Menopause? ☐ Yes ☐ No

Age of onset: _____

Vaginal dryness/painful intercourse?	☐ Yes	☐ No
Do you have hot flashes?	☐ Yes	☐ No
Trouble sleeping?	☐ Yes	☐ No
Night Sweats?	☐ Yes	☐ No

Patient Name: _____ DOB: _____

Past Medical History (continued)

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: _____

Do you douche? ☐ Yes ☐ No If so, how often? _____

What do you use?_____

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

☐ Yeast ☐ Chlamydia ☐ HPV/genital warts

☐ Trichomonas ☐ Gonorrhea ☐ Herpes/HSV virus

☐ Syphilis ☐ Bacteria/BV ☐ Pelvic inflammatory Disease

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

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

_____

Patient Name: _____ DOB: _____

Past Medical History (continued)

Do you have concerns with PMS? ☐ Yes ☐ No

Explain: _____

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

Past Obstetrical History (List all pregnancies including 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

Patient Name: _____ DOB: _____

Family History

Relation	Age	Age at Death	Medical Conditions
Mother			
Father			
Sister			
Sister			
Brother			
Brother			
Spouse			

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

Does any one 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? _____

Social History

Do you consume caffeine daily? ☐ Yes ☐ No
Servings per 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? _____

Patient Name: _____ DOB: _____

Social History (continued)

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 of yourself as: (Response to this question is optional)

☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual

☐ Something else ☐ Don't Know

Do you have concerns regarding your bladder? ☐ Yes ☐ No

_____

_____

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 one 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 ever have to apply pressure to your bladder or have to change positions to empty your bladder? ☐ Yes ☐ No

Do you ever apply pressure to your rectum to have a bowel movement?

☐ Yes ☐ No

Patient Name: _____ DOB: _____

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 testing? ☐ Yes ☐ No

Have you ever had surgery or treatment for any bladder issues? ☐ Yes ☐ No

Explain: _____

_____

Do you currently have:

Burning with urination? _____

Blood in your urine? _____

Frequency? _____

Urgency? _____

Do you perform monthly breast exams? ☐ Yes ☐ No

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

Do you have: ☐ Breast lumps ☐ Nipple discharge

☐ Breast tenderness

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION:

_____

_____

_____

_____

_____

_____

_____

Reviewed with patient: _____ Date: _____