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®)? __________

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?____

web0714

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

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

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?________________________________

Do you have concerns regarding your bladder?______ 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 surgery or treatment? ☐ Yes ☐ No

Explain____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

____

____

____

____

____

____

____

____

Provider signature: Reviewed with patient: ________________________________ Date: ________