



NEW PATIENT HISTORY

DATE:

| PERSONAL PROFILE | | | | | | |
|--|--------|---------------------|--|-----------------|----------------------|----------------------------------|
| NAME: | | | NAME YOU WOULD LIKE US TO USE: | | | |
| AGE: | | | OCCUPATION: | | | |
| BIRTH DATE: | | | MARITAL STATUS: | | | |
| GYNECOLOGIC HISTORY | | | | | | |
| ARE YOU CURRENTLY PREGNANT? | | | CURRENT BIRTH CONTROL: | | | |
| LAST MENSTRUAL PERIOD (FIRST DAY): | | | LAST PAP SMEAR: | | RESULT: | |
| AGE PERIODS BEGAN: | | | ABNORMAL PAP IN PAST? ___NO ___YES _____ | | | |
| NUMBER OF DAYS BLEEDING: | | | LAST MAMMOGRAM: | | | |
| NUMBER OF DAYS BETWEEN PERIODS: | | | ABNORMAL MAMMOGRAMS/BREAST BIOPSIES IN THE PAST? | | | |
| ANY RECENT CHANGES IN PERIODS? | | | ___NO ___YES (DATE) _____ | | | |
| ARE YOU CURRENTLY SEXUALLY ACTIVE? | | | LAST COLONOSCOPY: | | RESULT: | |
| SEXUAL ORIENTATION: | | | LAST BONE DENSITY SCAN: | | RESULT: | |
| OBSTETRIC HISTORY | | | | | | |
| | NUMBER | | NUMBER | | NUMBER | |
| TOTAL PREGNANCIES | | PREMATURE (<37 WKS) | | LIVING CHILDREN | | |
| FULL TERM | | ABORTIONS | | MISCARRIAGES | | |
| PLEASE LIST EACH PREGNANCY BELOW: | | | | | | |
| NO. | DATE | WEIGHT | SEX | WEEKS PREGNANT | COMPLICATIONS | TYPE OF DELIVERY (VAG/C-SECTION) |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| MEDICATIONS (INCLUDE OVER-COUNTER) | | | | | MEDICATION ALLERGIES | |
| DRUG NAME/DOSE | | | DRUG NAME/DOSE | | 1 | |
| 1 | | | 3 | | 2 | |
| 2 | | | 4 | | 3 | |

SOCIAL HISTORY

CIGARETTES ___ NEVER ___ CURRENT ___ PAST ___ PACKS PER DAY ___ YEARS

ALCOHOL ___ NONE ___ #DRINKS PER DAY ___ #DRINKS PER WEEK

RECREATIONAL DRUGS (DESCRIBE) ___ CURRENT ___ PAST

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE? ___ NO ___ YES

PERSONAL PAST MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (PAST OR CURRENT)

| | YES | NO | DETAILS (DATE/DESCRIPTION) |
|----------------------------------|-----|----|----------------------------|
| ABNORMAL HAIR GROWTH/HAIR LOSS | | | |
| ABNORMAL VAGINAL DISCHARGE | | | |
| ABNORMALLY PAINFUL/HEAVY PERIODS | | | |
| ARTHRITIS/JOINT PROBLEMS | | | |
| ASTHMA OR LUNG DISEASE | | | |
| BLOOD CLOTS IN LEGS OR LUNGS | | | |
| BLOOD TRANSFUSION | | | |
| BOWEL PROBLEMS | | | |
| CANCER | | | |
| DEPRESSION/ANXIETY | | | |
| DIABETES | | | |
| ENDOMETRIOSIS | | | |
| HEART ATTACK/ANGINA | | | |
| HERPES | | | |
| HIGH BLOOD PRESSURE | | | |
| INFERTILITY | | | |
| INVOLUNTARY LOSS OF STOOL | | | |
| INVOLUNTARY LOSS OF URINE | | | |
| IRREGULAR OR ABSENT PERIODS | | | |
| KIDNEY INFECTION/STONES | | | |
| LUMPS OR PAIN IN BREASTS | | | |
| LUPUS/ COLLAGEN VASCULAR DISEASE | | | |
| MENOPAUSE SYMPTOMS | | | |

| CONDITIONS CONTINUED: | YES | NO | DETAILS (DATE/DESCRIPTION) | |
|---------------------------------|-------------|-------------------------------|----------------------------|--|
| MIGRAINES/HEADACHES | | | | |
| REFLUX/STOMACH ULCER | | | | |
| SEIZURES | | | | |
| SEXUALLY TRANSMITTED DISEASES | | | | |
| STROKE | | | | |
| SUBSTANCE ABUSE | | | | |
| THYROID DISEASE | | | | |
| UNEXPLAINED WEIGHT LOSS OR GAIN | | | | |
| UTERINE FIBROIDS | | | | |
| OPERATIONS/ HOSPITALIZATIONS | | | | |
| PROCEDURE/ REASON HOSPITALIZED | DATE | HOSPITAL | COMPLICATIONS | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| FAMILY HISTORY | | | | |
| MOTHER | ___ LIVING | ___ DECEASED- | AGE/ CAUSE OF DEATH | |
| FATHER | ___ LIVING | ___ DECEASED- | AGE/ CAUSE OF DEATH | |
| SIBLINGS | #LIVING ___ | #DECEASED__ | AGES/ CAUSES OF DEATH | |
| CHILDREN | #LIVING ___ | #DECEASED__ | AGES/ CAUSES OF DEATH | |
| ILLNESS | YES | WHICH RELATIVES/ AGE OF ONSET | | |
| BIRTH DEFECTS | | | | |
| BLOOD CLOTS IN LEGS/LUNGS | | | | |
| BREAST CANCER | | | | |
| COLON CANCER | | | | |
| CYSTIC FIBROSIS | | | | |
| DOWNS SYNDROME | | | | |
| HEART DISEASE | | | | |
| HIGH BLOOD PRESSURE | | | | |

| FAMILY HISTORY CONTINUED | YES | WHICH RELATIVES/ AGE OF ONSET |
|---------------------------------|------------|--------------------------------------|
| HIGH CHOLESTEROL | | |
| OVARIAN CANCER | | |
| SICKLE CELL DISEASE | | |
| STROKE | | |
| TAY SACHS DISEASE | | |
| UTERINE CANCER | | |
| OTHER FAMILY HISTORY | | |

REVIEW OF SYSTEMS

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING BODY SYSTEMS? (MARK THOSE THAT APPLY)

| | | | | | |
|-----------------------|---------------------|-------------------------|----------------------|--------------|----------------|
| GENERAL | fatigue | fever | weight gain | weight loss | |
| HEAD/EARS/NOSE/THROAT | headaches | sore throat | decreased hearing | | |
| BREAST | breat lumps | breast tenderness | nipple discharge | | |
| CARDIOVASCULAR | chest pain | irregular heartbeat | | | |
| RESPIRATORY | shortness of breath | cough | wheezing | | |
| GASTROINTESTINAL | nausea | vomiting | diarrhea | constipation | abdominal pain |
| SKIN | rashes | skin lesions | | | |
| NEUROLOGIC | seizures | tingling | numbness | | |
| MUSCULOSKELETAL | joint pain | joint swelling | | | |
| ENDOCRINE | hair loss | temperature intolerance | abnormal hair growth | | |

GENERAL INFORMATION

PRIMARY CARE PHYSICIAN:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE:

ARE YOU HERE TODAY FOR A _____ ROUTINE ANNUAL EXAM OR A PROBLEM? _____

IF YOUR VISIT IS FOR A PROBLEM, PLEASE DESCRIBE:

THANK YOU!