



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			3			1
						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? (CIRCLE THOSE THAT APPLY)

GENERAL	fatigue	fever	significant weight gain or loss	other
SKIN	abnormal moles	rashes	other	
EYES/EARS/NOSE/THROAT	vision changes	hearing loss	sinus problems	sore throat other
RESPIRATORY	shortness of breath	cough	wheezing	other
CARDIOVASCULAR	chest pain	shortness of breath	other	
GASTROINTESTINAL	heartburn	nausea	vomiting	bowel movement changes other
URINARY	pain with urination	frequency	urgency	incontinence other
MUSCULOSKELETAL	arthritis	muscle aches	back pain	other
NEUROLOGIC	dizziness	numbness	seizures	other
PSYCHOLOGICAL	depression	anxiety	mood swings	premenstrual symptoms other

CURRENT VISIT 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!