Complete WOMENS CARE CENTER
obstetrics gynecology menopause fertility wellness cosmetic gynecology

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)

	DRUG NAME/DOSE		DRUG NAME/DOSE
1		3	
2		4	

MEDICATION ALLERGIES

1	
2	
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!