

**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:		
RECEIVED GARDASIL VACCINE? ___NO ___YES _____ (DATE)						
OBSTETRIC HISTORY						
	NUMBER		NUMBER		NUMBER	
TOTAL PREGNANCIES		PREMATURE (<37 WKS)		LIVING CHILDREN		
FULL TERM		ABORTIONS		MISCARRIAGES		
<b>PLEASE LIST EACH PREGNANCY BELOW:</b>						
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				
<b>MOTHER</b>	___ LIVING	___ DECEASED-	AGE/ CAUSE OF DEATH	
<b>FATHER</b>	___ LIVING	___ DECEASED-	AGE/ CAUSE OF DEATH	
<b>SIBLINGS</b>	#LIVING___	#DECEASED__	AGES/ CAUSES OF DEATH	
<b>CHILDREN</b>	#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				

<b>FAMILY HISTORY CONTINUED</b>	<b>YES</b>	<b>WHICH RELATIVES/ AGE OF ONSET</b>
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	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		

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!