New Patient
Past Medical History

The purpose of obtaining this information is to develop a comprehensive picture of your background. By completing these questions to the best of your ability, you will make it possible for your doctor to evaluate and treat you in the best clinical manner. This sheet will become a part or you medical record and will, therefore, be considered CONFIDENTIAL INFORMATION.

Name:_____ Today's Date:_____
Phone#: Home_____Cell_____ Referring Physician:_____
Pharmacy _____ Referring Physician #:_____

First day of last menstrual period:_____
What are you currently using to prevent pregnancy?_____
What is the reason for today's visit?_____

Allergies: List all medications to which you are allergic and the reactions you had with them. □ NONE

_____
_____
_____
_____

Have you ever had a reaction to latex, Band-Aids or rubber gloves?_____

Medications: List all medication you are currently taking. □ NONE

Medication	Dose	Frequency	Reason for Medication

PREGNANCIES

Date	M-miscarriage A-abortion E-ectopic	Gestational Age (# of weeks pregnant upon delivery)	Birth Weight	Sex (M or F)	V – Vaginal C – Cesarean Section	Complications

Name:_____ Today's Date:_____

GYN HISTORY

Are you currently having any of the following:

- □ Bleeding after menopause
- □ Amenorrhea (no periods for at least 3 months)
- □ Heavy or irregular periods
- □ Bleeding between periods of after intercourse
- □ Painful periods
- □ Sexual difficulties
- □ Painful intercourse
- □ Infertility
- □ Abnormal Pap smear
- □ Endometriosis
- □ Frequent yeast infections
- □ Urinary incontinence (leakage of urine)
- □ Straining with urination
- □ Burning with urination
- □ Urinary urgency
- □ How often do you get up in the night to urinate_____
- □ Any other gynecologic problems_____
  _____
- □ Did your mother take DES (diethyl stilbestrol) while pregnant with you?_____

Did you have intercourse before the age of 16? □ YES □ NO
Have you had 5 or more sexual partners? □ YES □ NO
Have you ever been touched or forced to have sexual contact with someone against your will? □ YES □ NO

Have you ever had any of the following sexually transmitted diseases? If so, when and were you treated?

- □ Herpes_____ □ Trichomonas_____ □ Gonorrhea_____
- □ Hepatitis B or C_____ □ Chlamydia_____ □ HIV_____
- □ Venereal Warts_____ □ Syphilis_____ □ HPV_____

PERSONAL PAST HISTORY

- □ Rheumatic Fever □ Liver Disease □ Diabetes □ Heart Murmur
- □ Clotting Disorder □ Thyroid Disease □ Cancer □ Anemia
- □ High Blood Pressure □ Depression □ Anxiety □ Asthma
- □ Alcoholism □ Arthritis □ Frequent bladder or kidney infections
- □ Other:_____

List any surgeries or hospitalizations you have had (except for pregnancy) _____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Marital Status:
□ Single □ Engaged □ Married □ Widowed □ Separated □ Divorced □ Living with significant other

Do you smoke? □ NO □YES Packs daily_____ How long_____ Stopped when_____
Caffeine consumption: □ NO □ YES Type_____ Amount_____
Alcohol consumption: □ NO □ YES Type_____ Amount_____

Name:_____ Today's Date:_____

FAMILY MEDICAL HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Breast Cancer						
Colon Cancer						
Heart Disease						
High Blood Pressure						
Diabetes						
Osteoporosis						
Uterine Cancer						
Ovarian Cancer						
Cervical Cancer/Dysplasia						
Fibroids						
Endometriosis						

REVIEW OF SYSTEMS

Currently do you have any problems with:

Constitutional symptoms
- □ Fatigue
- □ Fever
- □ Weight loss

Ears/Nose/Throat
- □ Deafness
- □ Mouth/tongue sores
- □ Sinusitis
- □ Voice changes

Endocrine
- □ Thirst, excessive
- □ Frequent urination

Eyes
- □ Glasses/contacts
- □ Visual loss

Cardiovascular
- □ Chest pain
- □ Exertional shortness of breath
- □ Irregular heartbeat
- □ Palpitations
- □ Swelling of ankles

Gastrointestinal
- □ Abdominal Pain
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids
- □ Nausea/vomiting
- □ Rectal bleeding

Genitourinary
- □ Blood in urine
- □ Burning on urination

Hematologic/Lymphatic
- □ Bruising
- □ Nosebleeds
- □ Swollen glands

Integumentary (skin)
- □ Moles that have changed
- □ Skin rash/itching

Musculoskeletal
- □ Backache
- □ Joint pain

Neurological
- □ Convulsions
- □ Migraines
- □ Memory problems
- □ Paralysis
- □ Trouble sleeping

Psychological
- □ Anxiety
- □ Depression

Respiratory
- □ Cough
- □ Wheezing

Breasts
- □ Tenderness
- □ Mass
- □ Nipple Discharge