NEW PATIENT HISTORY

DATE:

PERSONAL PROFILE

NAME:	NAME YOU WOULD LIKE US TO USE:
AGE:	OCCUPATION:
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 THE PAST? _____NO _____YES (DATE)_________
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 PREFERENCE:	LAST BONE DENSITY SCAN: RESULT:

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
TOTAL PREGNANCIES		PREMATURE (<37 WKS)		LIVING CHILDREN	
FULL TERM (37-42 WKS)		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			5		
2			6		
3			7		
4			8		

MEDICATION ALLERGIES

1	
2	
3	
4	
5	

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)
ASTHMA			
LUNG DISEASE/PNEUMONIA			
HEART ATTACK/ANGINA			
DIABETES			
HIGH BLOOD PRESSURE			
STROKE			
BLOOD CLOTS IN LEGS OR LUNGS			
LUPUS/ COLLAGEN VASCULAR DISEASE			
CANCER			
ANEMIA			
BLOOD TRANSFUSION			
HEPATITIS/LIVER DISEASE			
REFLUX/STOMACH ULCER			
BOWEL PROBLEMS			
ARTHRITIS/JOINT PROBLEMS			
GLAUCOMA			
MIGRAINES			
SEIZURES			
RECURRENT BLADDER INFECTIONS			
KIDNEY INFECTION/STONES			
HERPES			
HIV/AIDS			
OTHER SEXUALLY TRANSMITTED DISEASES			

CONDITION (CONTINUED)	YES	NO	DETAILS (DATE/DESCRIPTION)
INFERTILITY			
ENDOMETRIOSIS			
UTERINE FIBROIDS			
ABNORMALLY PAINFUL PERIODS			
ABNORMAL VAGINAL BLEEDING			
ABNORMAL VAGINAL DISCHARGE			
LUMPS IN BREASTS			
INVOLUNTARY LOSS OF URINE			
INVOLUNTARY LOSS OF STOOL			
ABNORMAL HAIR GROWTH			
HAIR LOSS			
UNEXPLAINED WEIGHT LOSS OR GAIN			
THYROID DISEASE			
MENOPAUSE SYMPTOMS			
DEPRESSION/ANXIETY			
SUBSTANCE ABUSE			

OPERATIONS/ HOSPITALIZATIONS

	PROCEDURE/ REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1				
2				
3				
4				
5				
6				

INJURIES/ ILLNESSES

	DATE	INJURY/ ILLNESS
1		
2		
3		
4		
5		

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**
DIABETES		
STROKE		
HEART DISEASE		
BLOOD CLOTS IN LEGS OR LUNGS		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
BIRTH DEFECTS		
DOWNS SYNDROME		
CYSTIC FIBROSIS		
TAY SACHS DISEASE		
SICKLE CELL DISEASE		
OVARIAN CANCER		
COLON CANCER		
UTERINE CANCER		
BREAST CANCER		
OTHER FAMILY HISTORY		

PATIENT SIGNATURE :

DATE REVIEWED BY PHYSICIAN: **PHYSICIAN SIGNATURE:**

ANNUAL REVIEW	**DATE:**	**PHYSICIAN SIGNATURE:**
	DATE:	**PHYSICIAN SIGNATURE:**
	DATE:	**PHYSICIAN SIGNATURE:**
	DATE:	**PHYSICIAN SIGNATURE:**