Print Form

OBSTETRICS AND GYNECOLOGY
NEW PATIENT HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

Reason for today's visit: _____

_____

Date of last menstrual period: _____

MEDICAL HISTORY

Arthritis	☐ yes	☐ no	_____
Asthma	☐ yes	☐ no	_____
Chronic lung disease	☐ yes	☐ no	_____
Cancer	☐ yes	☐ no	_____
Diabetes	☐ yes	☐ no	_____
Eye disease	☐ yes	☐ no	_____
Heart disease	☐ yes	☐ no	_____
Hypertension	☐ yes	☐ no	_____
Kidney disease	☐ yes	☐ no	_____
Liver disease	☐ yes	☐ no	_____
Psychiatric disorder	☐ yes	☐ no	_____
Seizures/Epilepsy	☐ yes	☐ no	_____
Stomach/Intestinal disease	☐ yes	☐ no	_____
Stroke	☐ yes	☐ no	_____
Thyroid disease	☐ yes	☐ no	_____
Other	☐ yes	☐ no	_____

HEALTH MAINTENANCE

Procedure	Date	Results
Last Mammogram	_____	_____
Last Bone Density	_____	_____
Last Cholesterol	_____	_____
Last colonoscopy	_____	_____

SURGICAL HISTORY

List any surgeries you have had and the approximate date.
Example: tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery/biopsy, laparoscopy

_____

_____

_____

_____

Have you had a blood transfusions ☐Yes ☐No If yes, when? _____

MEDICATIONS (including over the counter medications and supplements) **DOSE**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List any medications or foods that you are **ALLERGIC** to (and the reaction):

_____
_____

FAMILY HISTORY

Mother _____ ☐ Living ☐ Deceased

Father _____ ☐ Living ☐ Deceased

Siblings _____

		Relation to you
Diabetes	☐ yes ☐ no	_____
Hypertension	☐ yes ☐ no	_____
Thyroid disease	☐ yes ☐ no	_____
Cancer		
Breast	☐ yes ☐ no	_____
Ovarian	☐ yes ☐ no	_____
Colon	☐ yes ☐ no	_____
Other	☐ yes ☐ no	_____
Psychiatric illness	☐ yes ☐ no	_____
Osteoporoses	☐ yes ☐ no	_____
Other	☐ yes ☐ no	_____

OB/GYN

	NUMBER		NUMBER		NUMBER
Pregnancies	_____	Abortions	_____	Miscarriages	_____
Premature births	_____	Live births	_____	Living children	_____

BIRTH DATE	TYPE OF DELIVERY	WEEKS PREGNANCY	BIRTH WEIGHT	BABY'S SEX
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Pregnancy complications: ☐ Diabetes ☐ High blood pressure ☐ Other _____

History of depression before or after pregnancy? ☐ yes ☐ no _____

How old were you when you had your first period? _____
Are your cycles regular/monthly? ☐ Yes ☐ No
How many days does your period last? _____

If in menopause, at what age did it occur? _____ ☐ natural ☐ surgical ☐ chemical
Years of hormone replacement therapy? _____

When was your last pap smear? _____
Have you had any abnormal pap smears? ☐ Yes ☐ No When? _____
Have you been told you have HPV? ☐ Yes ☐ No When? _____
Have you had any treatments for abnormal pap smears? ☐ Yes ☐ No ☐ repeat pap ☐ colposcopy ☐ biopsy
Have you received HPV vaccine? ☐ Yes ☐ No Date _____

When was your last mammogram? _____
Have you had any abnormal mammograms? ☐ Yes ☐ No _____
Have you had any breast biopsies? ☐ Yes ☐ No If yes, when? _____
Do you do breast self examination? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No
Have you ever been sexually active? ☐ Yes ☐ No
At what age was your first intercourse? _____
How many lifetime sexual partners have you had? _____
Have you ever been sexually abused, threatened or hurt by anyone? _____

Do you currently have a partner? ☐ Yes ☐ No Partners age _____
How long have you been in this relationship? _____
Are you experiencing any sexual problems? _____

Current birth control
☐ None ☐ Timing ☐ Condoms Diaphragm ☐ Birth Control Pills/Patch/Ring
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal Ligation ☐ Vasectomy

Past birth control
☐ None ☐ Timing ☐ Condoms Diaphragm ☐ Birth Control Pills/Patch/Ring
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal Ligation ☐ Vasectomy

Have you ever been treated for any sexually transmitted infections?
☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Condyloma ☐ PID

Have you ever been tested for HIV? ☐ Yes ☐ No Date of last test: _____ Result ☐ Neg ☐ Pos

Have you ever had a yeast infection? ☐ Yes ☐ No Chronic yeast? _____
Have you ever been treated for a vaginal bacterial infection (bacterial vaginosis)? ☐ Yes ☐ No Chronic? _____

Have you ever been told you have fibroids of the uterus? _____
Have you ever had ovarian cysts? _____
Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in your urine? _____

SOCIAL HISTORY

Occupation _____
Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Children _____
Pets _____
Tobacco ☐ Yes ☐ No # of cigarettes/day ____ # of years _____
Alcohol ☐ Yes ☐ No # of drinks/day-week ____ type _____
Drugs ☐ Yes ☐ No _____
Exercise ☐ Yes ☐ No # of times/week _____ type _____
Health care proxy ☐ Yes ☐ No
Seat belt use ☐ Yes ☐ No

REVIEW OF SYSTEMS **Please check all that are applicable (within the last 6-12 months)**

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Feeling poorly
- ☐ Feeling tired
- ☐ Recent weight gain
- ☐ Recent weight loss

EYES
- ☐ Eye pain
- ☐ Wearing glasses
- ☐ Spots before eyes
- ☐ Vision changes
- ☐ Dry eyes
- ☐ Itchy eyes

EAR/NOSE/THROAT
- ☐ Earaches
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Dental problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart rate is fast
- ☐ Heart rate is slow
- ☐ Leg swelling (Edema)

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Dyspnea (shortness of breath) on exertion
- ☐ Shortness of breath with lying flat (Orthopnea)
- ☐ Respiratory distress in sleep (PND)

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Early satiety
- ☐ Heartburn
- ☐ Black stool (Melena)
- ☐ Maroon colored stool (Hematochezia)

OB/GYN GU
- ☐ Frequency
- ☐ Nocturia
- ☐ Dysuria
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Odor in urine
- ☐ Incomplete emptying of bladder
- ☐ Stress incontinence
- ☐ Urge incontinence

OBGYN
- ☐ Abnormal bleeding
- ☐ Irregular menses
- ☐ Pain with menses
- ☐ Pain with intercourse
- ☐ Anorgasmia
- ☐ Vulvar itching
- ☐ Midcycle bleeding
- ☐ Post coital bleeding
- ☐ Vulvar pain
- ☐ Decreased libido
- ☐ Vaginal itching
- ☐ Pelvic pain
- ☐ Vaginal dryness
- ☐ Pelvic pain
- ☐ Vaginal odor

MUSCULOSKELETAL
- ☐ Arthralgia (joint pain)
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Limb pain
- ☐ Limb swelling

INTEGUMENTARY (SKIN)
- ☐ Acne
- ☐ Breast discharge
- ☐ Itching
- ☐ Change in a mole
- ☐ Breast pain
- ☐ Breast lump

NEUROLOGICAL
- ☐ Confused
- ☐ Memory problems
- ☐ Dizziness
- ☐ Headaches/Migraines
- ☐ Limb weakness
- ☐ Difficulty walking

PSYCHIATRIC
- ☐ Suicidal
- ☐ Sleep disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Change in personality
- ☐ Emotional problems

ENDOCRINE
- ☐ Hair loss
- ☐ Hot flashes
- ☐ Heat/Cold intolerance
- ☐ Muscle weakness
- ☐ Deepening of the voice
- ☐ Feeling weak
- ☐ Dry skin

HEMATOLOGY/IMMUNOLOGY
- ☐ Easy bleeding
- ☐ Easing bruising
- ☐ Swollen glands
- ☐ Seasonal Allergies