Would you like a chaperone during your intimate exam today? ***Yes / No***

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 transfusion □ 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 _____ □ Living □ Deceased

		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	_____
Osteoporosis	□ yes □ no	_____
Other	□ yes □ no	_____

OB/GYN

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

BIRTH DATE	TYPE OF DELIVERY	WHEN/WHERE	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 (Gardasil)? □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

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? □yes □ no _____

Current birth control

□ None □ Timing □ Condom □ Diaphragm □ Birth control pills/ patch/ ring

□ Implants □ Depo Provera □ IUD □ Tubal Ligation □Vasectomy

Past birth control

□ None □ Timing □ Condom □ 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 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

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3
Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself – or that you are a failure or have left yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score to each column				

Total Score (add column score) _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Provider Signature:_____ **Date**: ___/___/___