New Patient History Form
(Age 18 and over)

Obstetrics & Gynecology

Name_____ Age_____ Date of Birth _____
first middle last

Occupation_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred to our office by:_____

What is the purpose of your visit?_____

_____

If you have a specific problem, please describe briefly:_____

_____

How long have you had this problem?_____

Have you consulted anyone else? ☐ Yes ☐ No Who?_____

Describe any previous testing and/or treatment:_____

_____

_____

Please list all medications you are currently taking. Please include over the counter medications and herbal supplements. _____

_____

_____

Please list all allergies to medications, latex, iodine, foods:_____

_____

GYNECOLOGY REVIEW

Last Pap Smear:_____ Last Mammogram:_____ Last Bone Density:_____

Did you receive HPV Vaccine Series (Gardasil®)? _____

Date of last normal period:_____ Age when your periods first started:_____

How often does your period come? Every _____ days

How many days do you usually bleed? _____

I use _____ pads and/or _____ tampons on my heaviest days
How many? How many?

Do you have significant pain with your periods? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Do you bleed or spot after sex? ☐ Yes ☐ No

Do you have to take any pain relievers during your period? ☐ Yes ☐ No

If yes, what do you usually take?_____ How much?_____

Name _____ Date of Birth _____

What form of birth control do you use?

☐ Birth control pills – Name:_____ How many years?_____

☐ IUD Type:_____ Date of insertion:_____

☐ Vasectomy ☐ Nexplanon / Date of insertion: _____

☐ Rhythm/Natural Family Planning ☐ Condoms/Foam/Suppositories

☐ Tubal Ligation ☐ Menopause

☐ Hysterectomy ☐ Patch/Vaginal Ring

☐ Other:_____

Have you reached Menopause? ☐ Yes ☐ No Age of onset:_____

Do you have hot flashes? ☐ Yes ☐ No Night sweats? ☐ Yes ☐ No

Vaginal dryness/painful intercourse? ☐ Yes ☐ No Trouble sleeping? ☐ Yes ☐ No

Have you taken hormone replacement therapy? ☐ Yes ☐ No

Medication taken_____

Duration of treatment?_____Reason for discontinuation?_____

Herbal or natural supplements_____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No What year?_____

Describe any treatment/follow-up:_____

_____

Do you have a vaginal discharge? ☐ Yes ☐ No Describe:_____

Have you used medication for the discharge? ☐ Yes ☐ No Medication used:_____

Have you been treated in the past for a vaginal infection? ☐ Yes ☐ No

☐ Yeast ☐ Chlamydia ☐ HPV/genital warts ☐ Trichomonas

☐ Gonorrhea ☐ Herpes/HSV virus ☐ Syphilis ☐ Bacterial/BV

☐ Pelvic Inflammatory Disease

Do you have pain during or after intercourse on a regular basis? ☐ Yes ☐No

Do you have any concerns with sexual function/desire? ☐ Yes ☐No

_____

Do you have concerns with PMS? ☐Yes ☐ No _____

Do you perform monthly breast self-exams? ☐ Yes ☐ No

Any significant breast changes that you have noticed? ☐ Yes ☐ No

Do you have: ☐ breast lumps ☐ nipple discharge ☐ breast tenderness

Name _____ Date of Birth _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

☐ High Blood Pressure
☐ Diabetes
☐ Kidney stones
☐ Lung Disease/COPD
☐ Heart Disease/heart attack
☐ Stroke
☐ Epilepsy/Seizures
☐ Asthma
☐ Deep Vein Thrombosis (DVT or PE)
☐ Thyroid Disease: _____
☐ Depression or ☐ Anxiety
☐ Osteoporosis/osteopenia: _____
☐ GERD/hiatal hernia
☐ Lupus/Rheumatoid Arthritis/Sjogren's
☐ HIV/AIDS
☐ Multiple Sclerosis
☐ Kidney Disease: _____
☐ Migraine Disorder: _____

☐ Hepatitis ☐ A ☐ B ☐ C

☐ Bleeding disorder (Von Willebrand/Hemophilia)

☐ Cancer Type:

☐ Other_____

SOCIAL HISTORY

Do you consume caffeine daily? ☐ Yes ☐ No Servings/day _____

Do you drink alcohol on a regular basis? ☐ Yes ☐ No Drinks/week _____

Do you smoke? ☐ Yes ☐ No Packs/day_____

Have you smoked cigarettes in the past? ☐ Yes ☐ No When did you quit?_____

Do you use drugs on a regular basis? ☐ Yes ☐ No

Type and how much?_____

Have you used IV drugs in the past? ☐ Yes ☐ No

Do you think yourself as: *(Response to this question is optional)*

☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Something else ☐ Don't know

Do you have a history of physical/sexual/emotional abuse? ☐ Yes ☐ No

If yes, did you undergo counseling/treatment? ☐ Yes ☐ No

Is this something you would like to talk about? ☐Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No

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OBSTETRICAL HISTORY

Please list pregnancies, miscarriages, and terminations from past to current:

Date	Length of pregnancy	D&C	Vaginal / C-Section	Girl/Boy	Weight	Complications

SURGERIES AND HOSPITALIZATIONS *(Use a separate piece of paper if more space is needed)*

Surgery/Hospitalization	Date	Reason/Diagnosis

WOULD YOU ACCEPT A BLOOD TRANSFUSION IF NEEDED IN CASE OF EMERGENCY? ☐ YES ☐ NO

FAMILY HISTORY

Relationship	Age	Age at Death	Medical conditions
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Spouse			

Does anyone in your family have Breast Cancer? ☐ Yes ☐ No Who?_____

Does anyone in your family have Ovarian Cancer? ☐ Yes ☐ No Who?_____

Does anyone in your family have Colon Cancer? ☐ Yes ☐ No Who?_____

Name _____ Date of Birth _____

Does anyone in your family have Osteoporosis? ☐ Yes ☐ No Who?_____

Do you have concerns regarding your bladder?_____ If yes, answer the following questions:

Do you currently have:

_____Burning with urination

_____Blood in your urine

_____Frequency

_____Urgency

Do you leak urine when you cough/laugh/exercise/sneeze/have sex? ☐ Yes ☐ No

How many times a day do you leak?_____

If you leak on a regular basis, do you leak small or large amounts?_____

Do you have to wear a pad regularly because of your leakage? ☐ Yes ☐ No

How many pads do you use in 1 day?_____

How many times a night do you get up to urinate?_____

If you need to urinate, can you make it to the bathroom or do you leak on the way?_____

Do you feel like you can completely empty your bladder? ☐ Yes ☐ No

Do you have to apply pressure to your bladder or change positions to empty your bladder? ☐ Yes ☐ No

Do you ever have to apply pressure to your rectum to have a bowel movement? ☐ Yes ☐ No

Have you had a history of Urinary tract infections? ☐ Yes ☐ No

How many in the past year?_____

Have you ever seen a Urologist? ☐Yes ☐ No

Have you ever had surgery or treatment? ☐ Yes ☐ No

Explain_____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

_____

_____

_____

_____

Provider signature: Reviewed with patient: _____ Date: _____