New Patient History Form

(Less Than 18 Years of Age)

Obstetrics & Gynecology

Name____ Age_____ Date of Birth ___________
first middle last

Form Completed By_________________________ Relationship To Patient_________________________

Are you in school? ☐ Yes ☐ No If yes, where?____

Referred to our office by:____

What is the purpose of your visit?____

____

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

Have you had a period? ☐ Yes ☐ No

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

If yes, what do you usually take? ____________________________ How much?______________________

Do you have PMS? ☐ Yes ☐ No ____

Do you use birth control? ☐ Yes ☐ No If so, what kind? ____________________________________

Did you receive the HPV Vaccine (Gardasil®)? ☐ Yes ☐ No

Patient Name______________________________ **DOB**____________

OTHER GYNECOLOGY COMPLAINTS

Do you have abnormal 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

If yes, with what medicines?______________________________

What type of vaginal infection was it?______________________________

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 Do you feel safe at school? ☐ Yes ☐ No

Do you currently have problems with urination? ☐ Yes ☐ No If yes, please describe: ____________

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

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

SOCIAL HISTORY

Who lives with you in your house?______________________________

Have you ever smoked? ☐ Yes ☐ No If yes, please describe: ____________________

Have you ever tried alcohol? ☐ Yes ☐ No If yes, please describe: ____________________

Have you ever tried drugs? ☐ Yes ☐ No If yes, please describe: ____________________

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

web0714

Patient Name____ DOB_____________

FAMILY HISTORY

Relationship	Age	Age at Death	Medical Conditions
Father			
Mother			
Brother			
Brother			
Sister			
Sister			

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?__________________________

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

Does anyone in your family have DVT or PE history? ☐ Yes ☐ No Who?__________________________

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/pulmonary embolus

☐ Bleeding disorder (Von Willebrand/Hemophilia)

☐ Cancer Type: _______________________

Hepatitis ☐ A ☐ B ☐ C

☐ Thyroid Disease: __________________________

☐ HIV/AIDS

☐ Osteoporosis/osteopenia: ____________________

☐ GERD/hiatal hernia

☐ Lupus/Rheumatoid Arthritis/Sjogren's

☐ Depression or ☐ Anxiety

☐ Multiple Sclerosis

☐ Kidney Disease: ___________________________

☐ Migraines: _______________________________

☐ Other____________________________________

☐ Other____________________________________

☐ Other____________________________________

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

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Provider signature: Reviewed with patient: _________________________ Date: _________