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New Patient History:

Date of Appointment ___/___/___

Name _____ Date of Birth ___/___/___ Primary Care Physician _____

Reason for Visit: _____

REVIEW OF SYSTEMS (have you had any of these recently?)

YES	NO		YES	NO	
		General			Genitourinary
		Feeling well			Vaginal discharge
					Vaginal itching/burning
		Skin			Spotting between periods
		New lesions			Leakage of urine
		Rash			Urinary complaints
		ENT/Eyes			Musculoskeletal
		Head injury			Muscle weakness
		Double vision			Muscle soreness (myalgias)
		ringing in ears			
					Neurological
		Neck			Trouble walking
		Swollen glands			Numbness/tingling (paresthesias)
					Weakness in extremities
		Lungs			
		Difficulty breathing			Psychological
		Shortness of breath			Fearful
					Hallucinations
		Breasts			Mood changes
		Breast mass			
		Breast pain			Endocrine
		Nipple discharge			Appetite changes
					Excessive thirst
		Heart			Hair changes
		Chest pain			
		Palpitations			Hematology
					Excessive bleeding
		Gastrointestinal			Easy bruising
		Change in bowel habits			Enlarged lymph nodes
		Indigestion			

ALLERGIES: List any allergies to medication, drugs, chemicals or foods **and your REACTION**

Family History

Mother: [] Living [] Deceased - Cause: Age:
 Father: [] Living [] Deceased - Cause: Age:
 Siblings: Number Living Number Deceased: Cause(s)/Age(s):

ILLNESS	YES	WHICH RELATIVE	AGE	ILLNESS	YES	WHICH RELATIVE	AGE
Breast Cancer				Mental Illness			
Ovarian Cancer				Alcoholism/Drug Abuse			
Uterine Cancer				Diabetes			
Prostate Cancer				Heart Disease			
Colon Cancer				High Blood Pressure			
Endometriosis				Stroke			
Osteoporosis				High Cholesterol			
Blood Clots				Alzheimer's Disease			
Birth Defects				Others:			
Depression							

Past Medical and Surgical History

Have you ever had:

YES	NO	ILLNESS/DISEASE	DATES	YES	NO	Illness/DISEASE	DATES
		Anemia				Fibromyalgia	
		Anesthesia Reaction				Gall Bladder Disease	
		Anxiety Disorder				Gastric Reflux	
		Arthritis				Glaucoma	
		Asthma				-----Narrow Angle	
		Attention Deficit Disorder (ADD)				-----Wide Angle	
		Bipolar Disorder				Heart Disease	
		Blood Clot				Heart Murmur	
		-----in leg				High Cholesterol/Triglycerides	
		-----in lung				High Blood Pressure	
		Blood Transfusion				Kidney Disease	
		Bowel Disorder				Kidney Stones	
		-----Chronic Constipation				Liver Disease	
		-----Irritable Bowel (IBS)				Lung Disease	
		-----Diverticulosis				Lupus	
		-----Hemorrhoids				Migraine Headaches	
		-----Crohn's Disease				Pneumonia	
		-----Ulcerative Colitis				Rheumatic Fever	
		Cancer type _____				Seizures	
		Chronic Urinary Tract Infections				Stroke	
		Interstitial Cystitis				Thyroid Disease	
		Depression				Tuberculosis	
		Diabetes				Ulcers	
		Eating Disorder					

Please list **ALL** other MEDICAL PROBLEMS & dates:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list **ALL** SURGERIES and dates:

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH MAINTENANCE

Last Mammogram ___/___/___ Normal? Yes / No Findings: _____
Last Colonoscopy ___/___/___ Normal? Yes / No Findings: _____
Last Bone Density Scan ___/___/___ Normal? Yes / No Findings: _____
Last Cholesterol Check ___/___/___ Normal? Yes / No Findings: _____
Last cardiovascular Stress Test ___/___/___ Normal? Yes / No Findings: _____

GYNECOLOGIC HISTORY

Menstrual / Pap History:

Age of first period: _____ Date of last menstrual period? ___/___/___

History of uterine fibroids? No / Yes }
History of endometriosis? No / Yes } Date of last ultrasound? ___/___/___

Date of last Pap Smear ___/___/___ Was your last Pap Smear ABNORMAL? No / Yes
Have you ever had an abnormal Pap Smear? No / Yes ___/___/___
History of a procedure on your cervix? No / Yes
Colposcopy / Biopsy ___/___/___ Cryotherapy ___/___/___
LEEP ___/___/___ Laser ___/___/___
Cervical Conization ___/___/___ Other ___/___/___

Infections: Please circle any of the following infections that you have had in the past.

- Yeast Bacterial vaginosis/gardnerella Trichomonas Chlamydia
- Gonorrhea Pelvic Inflammatory Disease/PID Genital warts/condyloma/HPV
- Oral Herpes Genital Herpes Hepatitis B Hepatitis C
- HIV/AIDS Syphilis

Contraception: (examples: condoms, birth control pills, IUD, tubal, abstinence) **DO NOT ANSWER IF MENOPAUSAL**

Current method of birth control: _____ Past Method(s): _____

Hormone Replacement: (examples: nothing, estrogen, progesterone, soy) **ANSWER ONLY IF MENOPAUSAL**

Current hormone replacement: _____ Past Treatment(s): _____

SOCIAL HISTORY

Do you smoke? (Circle) Yes No How many per day? _____ Number of Years _____
Past smoker? (Circle) Yes No Number of years since you quit _____
Do you drink? (Circle) Yes No Number of drinks per day _____ Number of drinks per week _____

Please circle: Single Married Engaged Divorced Separated Living with Partner Widowed
Occupation: _____ Full time Part time Retired Disabled Student

Do you exercise? (Circle) Yes No How many times per week _____ Type of exercise _____
Balanced diet? (Circle) Yes No Do you take calcium supplements? (Circle) Yes No

Do you perform self breast exams? (Circle) Monthly Sporadically Never
Are you exposed to domestic violence? (Circle) Yes No

SEXUAL HISTORY (You may omit this if you prefer):

Are you currently sexually active? Yes No Have you ever had sex? Yes No

Sexual Orientation (circle): Heterosexual Homosexual Bisexual

Age of first Intercourse _____

Do you have any problems with sex? (Pain/desire/orgasm) _____

MEDICATIONS: List **ALL** medications you take regularly or within the past 6 months.

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |
| 6. _____ | 11. _____ |
| 7. _____ | 12. _____ |

PHARMACY (REQUIRED) Name _____ Location _____ Ph _____

OBSTETRICAL HISTORY

	NUMBER		NUMBER
Pregnancies		Live Births	
Living Children		Miscarriages/Abortions	
Premature Births		Ectopic Pregnancies	

No.	Birth Date	Weeks Pregnant	Birth Weight	Sex	Complications-Including Infections
1					
2					
3					
4					
5					

PHYSICAL EXAMINATION

Constitutional

Height: _____ Weight: _____ Blood Pressure: _____ Temperature: _____ HgB _____
 U/A _____