

# NEW PATIENT HISTORY

DATE: \_\_\_\_\_

## PERSONAL PROFILE

|                 |                                |
|-----------------|--------------------------------|
| NAME:           | NAME YOU WOULD LIKE US TO USE: |
| AGE:            | OCCUPATION:                    |
| MARITAL STATUS: |                                |

## GYNECOLOGIC HISTORY

|                                    |   |
|------------------------------------|---|
| ARE YOU CURRENTLY PREGNANT?        | CURRENT BIRTH CONTROL:  |
| LAST MENSTRUAL PERIOD (FIRST DAY): | LAST PAP SMEAR:                      RESULT:  |
| AGE PERIODS BEGAN:                 | ABNORMAL PAP IN THE PAST? <input type="checkbox"/> NO <input type="checkbox"/> YES (DATE) _____ |
| NUMBER OF DAYS BLEEDING:           | LAST MAMMOGRAM:   |
| NUMBER OF DAYS BETWEEN PERIODS:    | ABNORMAL MAMMOGRAMS/BREAST BIOPSIES IN THE PAST?  |
| ANY RECENT CHANGES IN PERIODS?     | <input type="checkbox"/> NO <input type="checkbox"/> YES (DATE) _____                           |
| ARE YOU CURRENTLY SEXUALLY ACTIVE? | LAST COLONOSCOPY:                      RESULT:  |
| SEXUAL PREFERENCE:                 | LAST BONE DENSITY SCAN:                      RESULT:  |

## OBSTETRIC HISTORY

|                       |        |                     |        |                 |        |
|-----------------------|--------|---------------------|--------|-----------------|--------|
|                       | NUMBER |                     | NUMBER |                 | NUMBER |
| TOTAL PREGNANCIES     |        | PREMATURE (<37 WKS) |        | LIVING CHILDREN |        |
| FULL TERM (37-42 WKS) |        | ABORTIONS           |        | MISCARRIAGES    |        |

**PLEASE LIST EACH PREGNANCY BELOW:**

| NO. | DATE | WEIGHT | SEX | WEEKS PREGNANT | COMPLICATIONS | TYPE OF DELIVERY (VAG/C-SECTION) |
|-----|------|--------|-----|----------------|---------------|----------------------------------|
| 1   |      |        |     |                |               |                                  |
| 2   |      |        |     |                |               |                                  |
| 3   |      |        |     |                |               |                                  |
| 4   |      |        |     |                |               |                                  |
| 5   |      |        |     |                |               |                                  |

| MEDICATIONS (INCLUDE OVER-COUNTER) | MEDICATION ALLERGIES |
|------------------------------------|----------------------|
|------------------------------------|----------------------|

|   | DRUG NAME | DOSE | DRUG NAME | DOSE |   |  |
|---|-----------|------|-----------|------|---|--|
| 1 |           |      | 5         |      | 1 |  |
| 2 |           |      | 6         |      | 2 |  |
| 3 |           |      | 7         |      | 3 |  |
| 4 |           |      | 8         |      | 4 |  |
| 5 |           |      |           |      | 5 |  |

## SOCIAL HISTORY

**CIGARETTES**    \_\_\_ NEVER    \_\_\_ CURRENT    \_\_\_ PAST    \_\_\_ PACKS PER DAY    \_\_\_ YEARS

**ALCOHOL**    \_\_\_ NONE    \_\_\_ #DRINKS PER DAY    \_\_\_ #DRINKS PER WEEK

**RECREATIONAL DRUGS (DESCRIBE)**    \_\_\_ CURRENT    \_\_\_ PAST

**HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?** \_\_\_ NO    \_\_\_ YES

## PERSONAL PAST MEDICAL HISTORY

**HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (PAST OR CURRENT)**

|                                     | YES | NO | DETAILS (DATE/DESCRIPTION) |
|-------------------------------------|-----|----|----------------------------|
| ASTHMA                              |     |    |                            |
| LUNG DISEASE/PNEUMONIA              |     |    |                            |
| HEART ATTACK/ANGINA                 |     |    |                            |
| DIABETES                            |     |    |                            |
| HIGH BLOOD PRESSURE                 |     |    |                            |
| STROKE                              |     |    |                            |
| BLOOD CLOTS IN LEGS OR LUNGS        |     |    |                            |
| LUPUS/ COLLAGEN VASCULAR DISEASE    |     |    |                            |
| CANCER                              |     |    |                            |
| ANEMIA                              |     |    |                            |
| BLOOD TRANSFUSION                   |     |    |                            |
| HEPATITIS/LIVER DISEASE             |     |    |                            |
| REFLUX/STOMACH ULCER                |     |    |                            |
| BOWEL PROBLEMS                      |     |    |                            |
| ARTHRITIS/JOINT PROBLEMS            |     |    |                            |
| GLAUCOMA                            |     |    |                            |
| MIGRAINES                           |     |    |                            |
| SEIZURES                            |     |    |                            |
| RECURRENT BLADDER INFECTIONS        |     |    |                            |
| KIDNEY INFECTION/STONES             |     |    |                            |
| HERPES                              |     |    |                            |
| HIV/AIDS                            |     |    |                            |
| OTHER SEXUALLY TRANSMITTED DISEASES |     |    |                            |

| CONDITION (CONTINUED)           | YES | NO | DETAILS (DATE/DESCRIPTION) |
|---------------------------------|-----|----|----------------------------|
| INFERTILITY                     |     |    |                            |
| ENDOMETRIOSIS                   |     |    |                            |
| UTERINE FIBROIDS                |     |    |                            |
| ABNORMALLY PAINFUL PERIODS      |     |    |                            |
| ABNORMAL VAGINAL BLEEDING       |     |    |                            |
| ABNORMAL VAGINAL DISCHARGE      |     |    |                            |
| LUMPS IN BREASTS                |     |    |                            |
| INVOLUNTARY LOSS OF URINE       |     |    |                            |
| INVOLUNTARY LOSS OF STOOL       |     |    |                            |
| ABNORMAL HAIR GROWTH            |     |    |                            |
| HAIR LOSS                       |     |    |                            |
| UNEXPLAINED WEIGHT LOSS OR GAIN |     |    |                            |
| THYROID DISEASE                 |     |    |                            |
| MENOPAUSE SYMPTOMS              |     |    |                            |
| DEPRESSION/ANXIETY              |     |    |                            |
| SUBSTANCE ABUSE                 |     |    |                            |

**OPERATIONS/ HOSPITALIZATIONS**

|   | PROCEDURE/ REASON HOSPITALIZED | DATE | HOSPITAL | COMPLICATIONS |
|---|--------------------------------|------|----------|---------------|
| 1 |                                |      |          |               |
| 2 |                                |      |          |               |
| 3 |                                |      |          |               |
| 4 |                                |      |          |               |
| 5 |                                |      |          |               |
| 6 |                                |      |          |               |

**INJURIES/ ILLNESSES**

|   | DATE | INJURY/ ILLNESS |
|---|------|-----------------|
| 1 |      |                 |
| 2 |      |                 |
| 3 |      |                 |
| 4 |      |                 |
| 5 |      |                 |

## FAMILY HISTORY

**MOTHER**      \_\_\_ LIVING      \_\_\_ DECEASED- AGE/ CAUSE OF DEATH

**FATHER**      \_\_\_ LIVING      \_\_\_ DECEASED- AGE/ CAUSE OF DEATH

**SIBLINGS**      #LIVING \_\_\_      #DECEASED \_\_\_      AGES/ CAUSES OF DEATH

**CHILDREN**      #LIVING \_\_\_      #DECEASED \_\_\_      AGES/ CAUSES OF DEATH

| ILLNESS                      | YES | WHICH RELATIVES/ AGE OF ONSET |
|------------------------------|-----|-------------------------------|
| DIABETES                     |     |                               |
| STROKE                       |     |                               |
| HEART DISEASE                |     |                               |
| BLOOD CLOTS IN LEGS OR LUNGS |     |                               |
| HIGH BLOOD PRESSURE          |     |                               |
| HIGH CHOLESTEROL             |     |                               |
| BIRTH DEFECTS                |     |                               |
| DOWNS SYNDROME               |     |                               |
| CYSTIC FIBROSIS              |     |                               |
| TAY SACHS DISEASE            |     |                               |
| SICKLE CELL DISEASE          |     |                               |
| OVARIAN CANCER               |     |                               |
| COLON CANCER                 |     |                               |
| UTERINE CANCER               |     |                               |
| BREAST CANCER                |     |                               |
| OTHER FAMILY HISTORY         |     |                               |

**PATIENT SIGNATURE :**

**DATE REVIEWED BY PHYSICIAN:**

**PHYSICIAN SIGNATURE:**

**ANNUAL REVIEW**

**DATE:**

**PHYSICIAN SIGNATURE:**

**DATE:**

**PHYSICIAN SIGNATURE:**

**DATE:**

**PHYSICIAN SIGNATURE:**

**DATE:**

**PHYSICIAN SIGNATURE:**