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New Patient History

I. Identifying Information

Name: ______________________ Date: ______________

How would you like to be contacted with test results? ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Email

☐ Cell Phone#______________ ☐ Ok to leave results on voicemail ☐ No results on machine

☐ Preventative/well-woman exam ☐ Reason for visit if problem: ______________

Age: ________ Marital Status: ________ Occupation: ______________

Who referred you?______________

Name of internist or family doctor:______________

Name of last gynecologist: ______________

Partner's name: ______________ Occupation: ______________

Children's names: ______________

Does your insurance cover preventative/well-woman exams? ☐ Yes ☐ No ☐ Unknown

List any other physicians or health care providers you see:

II: Medication History

List all medications that you take with the dose and timing: ☐ None

Drug	Dose	Frequency	Reason for medication	Prescribing MD

Do you take hormone therapy or birth control pills? Please list type, dose and timing: ☐ None

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: ☐ None

Your height: ____________________ Your weight: ____________________ Your blood type: ______________________
How much alcohol do you drink/week? ☐ None ☐ Avg. less than 1/day ☐ Avg. 1/day ☐ Avg. more
Do you smoke? ☐ Yes ☐ No Amount/day _____________ How many years _____________________________
If you quit smoking, when did you stop?
____
Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type: ____________________________
Are you currently dieting or do you have a non-traditional diet? ☐ Yes ☐ No
Please explain: ____
Do you perform self breast examinations monthly? ☐ Yes ☐ No
Do you have an advance directive for health care? ☐ Yes ☐ No
Have you been immunized or had the following?
Hepatitis A ☐ yes ☐ no
Tetanus: Last booster greater than 10 years? ☐ Yes ☐ No
Chickenpox (Varicella) ☐ yes ☐ no ☐ unknown
Date of last TB test: ________ ☐ positive ☐ negative
Hepatitis B ☐ yes ☐ no
Pneumococcus ☐ yes ☐ no ☐ unknown
Rubella (MMR) ☐ yes ☐ no ☐ unknown
Last flu shot: ___________________________________
Guardisil ☐ yes ☐ no

VI. Gynecologic History

Date of last menstrual period: ________________ ☐ Menopausal ☐ Hysterectomy
Length of cycle from first day to first day each month: __________ days ☐ Regular ☐ Irregular
Average length of each period: ___________ ☐ Heavy ☐ Moderate ☐ Light
What do you use to keep from getting pregnant? ☐ Nothing ☐ Vasectomy ☐ Condoms ☐ Rhythm
☐ Tubal ligation ☐ IUD ☐ Diaphragm ☐ Birth Control Pills ☐ Patch ☐ Abstinence

Please check if you have had the following:

Cramps ☐
Endometriosis ☐
Ovarian cysts ☐
Gonorrhea ☐
Condyloma (warts) ☐
Mycoplasma/Ureoplasma ☐
Laser/Freezing of cervix ☐
PMS ☐
Fibroids ☐
Pelvic adhesions ☐
Syphilis ☐
Abnormal pap smear ☐
Trichomonas ☐
Recent change in periods ☐
Incontinence of urine ☐
Herpes ☐
Chlamydia ☐
Recurrent vaginitis ☐
HPV ☐

Sexual history:

Are you sexually active? ☐ Yes ☐ No
Do you have pain with intercourse? ☐ Yes ☐ No
How many sexual partners have you had in your lifetime? ____________
How many sexual partners have you had in the last year? ____________
Have you ever been sexually abused or assaulted? ☐ Yes ☐ No
Are you personally concerned about AIDS? ☐ Yes ☐ No
Any sexual problems at this time? ☐ Yes ☐ No

Infertility History: (complete if indicated)

How long have you been trying unsuccessfully to become pregnant? ____________________
Please describe any tests/diagnosis/treatments you have performed:
____
____
____

Urologic History: (Complete if indicated)

Do you lose urine against your will? ☐ Yes ☐ No
Does your incontinence occur after coughing, exercising, sneezing, or lifting? ☐ Yes ☐ No
Do you have a strong sense of urgency to void just prior to losing your urine? ☐ Yes ☐ No
Do you wear a pad to protect against urine loss? ☐ Yes ☐ No

Allergies: List all adverse reactions or allergies you have to medications and what happened. ☐ None

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III. Surgical History ☐ None

List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom teeth.

Date	Operation	Diagnosis	Hospital/MD

IV. Medical History ☐ None

Please list any medical problems that you have, the physician taking care of you and how they are treated.

Date	Medical problem	Medication or treatment	Physician

Have you had any hospitalization, injuries, fractures or motor vehicle accidents not listed elsewhere? ☐ N/A

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Check if you have or have you ever had:

Alcohol abuse	☐	Anesthetic reaction	☐	Bleeding disorder	☐
Asthma	☐	Anemia	☐	Chronic lung condition	☐
Blood clots	☐	Drug and substance abuse	☐	Depression/anxiety	☐
Diabetes	☐	Heart disease	☐	High blood pressure	☐
High cholesterol	☐	Hepatitis/Jaundice	☐	Lupus or autoimmune disorder	☐
Irritable bowel syndrome	☐	Kidney stones	☐	Hypothyroidism	☐
Seizure disorder	☐	Stroke	☐	Tuberculosis	☐
Stomach ulcers	☐	Mitral valve prolapse	☐	Rheumatic fever	☐
Transfusion reaction	☐	Eating disorder	☐	Cancer	☐

Please explain: ______________________________

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V. General Health

Date/place of last pap smear: ☐ None ______________________________

Date/place of last mammogram: ☐ None ______________________________

Date/place of last blood work ☐ None ______________________________

Pregnancy history: ☐ No pregnancies

Number of times pregnant _______ Full term births _______ Premature births _______ Elective termination _______

Miscarriages _______ Ectopic pregnancies _______ Adopted children _______ Step children _______ Twins _______

Please list your pregnancy history:

Early pregnancy loss: List date and length of pregnancy with outcome

Date	Miscarriage/number of weeks	Elective abortion/number of weeks	Hospital/Doctor

Pregnancies lasting more than 20 weeks:

Date	Length of preg in weeks	Vaginal or C-section	Sex and weight	Hospital/Doctor	Complications

FAMILY HISTORY: ☐ Adopted

	Current age	Age at death	Health problems or cause of death
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

Please Explain:

Which of your 1st degree family members have the following

Breast cancer: ____________________

Ovarian cancer: ____________________

Colon cancer: ____________________

Other cancers: ____________________

Diabetes: ____________________

Heart disease: ____________________

High Blood Pressure: ____________________

Asthma: ____________________

Stroke: ____________________

High cholesterol: ____________________

Bleeding disorders: ____________________

Drug abuse: ____________________

Drinking problem: ____________________

Anesthesia Problems ____________________

VII. SYSTEMS REVIEW: Do you have or have you had?

HEENT	Current	Past	N/A
Migraines	❑	❑	❑
Chronic headaches	❑	❑	❑
Wear glasses or contacts	❑	❑	❑
Visual changes	❑	❑	❑
Spots before eyes	❑	❑	❑
Glaucoma	❑	❑	❑
Hearing loss	❑	❑	❑
Ringing in the ears	❑	❑	❑
Dizziness	❑	❑	❑
Chronic sinus problems	❑	❑	❑
Hay fever	❑	❑	❑
Dental problems	❑	❑	❑
Sore throat	❑	❑	❑
CARDIOVASCULAR			
Chest pain	❑	❑	❑
Difficulty breathing on exertion	❑	❑	❑
Wheezing/heart palpitations	❑	❑	❑
Chronic cough	❑	❑	❑
Abnormal chest x-ray	❑	❑	❑
Leg swelling	❑	❑	❑
Varicose veins	❑	❑	❑
Heart Murmur/Mitral Valve Prolapse	❑	❑	❑
Take antibiotics for dental work	❑	❑	❑
GASTROINTESTINAL			
Chronic abdominal pain	❑	❑	❑
Frequent nausea & vomiting	❑	❑	❑
Lactose intolerance	❑	❑	❑
Chronic constipation	❑	❑	❑
Persistent diarrhea	❑	❑	❑
Bloody stools	❑	❑	❑
Black stools	❑	❑	❑
Hemorrhoids	❑	❑	❑
HEMATOLOGY			
Frequent bruising	❑	❑	❑
Cuts that do not stop bleeding	❑	❑	❑
Enlarged lymph nodes	❑	❑	❑
URINARY			
Kidney infection/Pyelonephritis	❑	❑	❑
Recurrent bladder infections	❑	❑	❑
Blood in the urine	❑	❑	❑
Painful urination	❑	❑	❑
Kidney stones	❑	❑	❑
NEUROLOGIC			
Any neurological disorders	❑	❑	❑
Fainting	❑	❑	❑
Numbness	❑	❑	❑
Weakness	❑	❑	❑
Head or nerve injury	❑	❑	❑
Anxiety/Depression	❑	❑	❑
Counseling	❑	❑	❑
Joint pain/arthritis	❑	❑	❑
Back/disc disease	❑	❑	❑
Osteoporosis	❑	❑	❑

BREAST	Current	Past	N/A
Breast lump	❑	❑	❑
Breast tenderness	❑	❑	❑
Breast secretion	❑	❑	❑
Bleeding from nipples	❑	❑	❑
Breast implants	❑	❑	❑
SKIN			
Rash	❑	❑	❑
Mass	❑	❑	❑
Skin disorder	❑	❑	❑
Ulcer	❑	❑	❑
Moles changing size or color	❑	❑	❑
METABOLIC			
Abnormal thirst	❑	❑	❑
Excessive fatigue	❑	❑	❑
Heat or cold intolerance	❑	❑	❑
Unusual loss of hair	❑	❑	❑
Recent weight change	❑	❑	❑
Goiter (enlarged thyroid)	❑	❑	❑

TESTING (list date of test if performed and where performed)

Cystoscopy: ______________________

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EKG: ______________________

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Echocardiogram: ______________________

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Chest XRay: ______________________

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EEG: ______________________

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MRI: ______________________

Head ______________________

Abdomen ______________________

____

IVP: ______________________

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Ultrasound ______________________

Gall bladder ______________________

Abdomen ______________________

Pelvis ______________________

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Sigmoidoscopy ______________________

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Colonoscopy ______________________

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Bone Density Test: ______________________

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Upper GI ______________________

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Lower GI/Barium enema ______________________

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Endoscopy ______________________

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Please Explain: