OBSTETRICS AND GYNECOLOGY
NEW PATIENT HISTORY

Name _____ Date of Birth _____ Today's date _____

Primary Care Physician _____

Preferred Pharmacy _____ Pharmacy address _____ Phone _____

Reason for today's visit _____

_____

Date of last menstrual period _____

OB HISTORY

	NUMBER		NUMBER		NUMBER
Pregnancies	_____	abortions	_____	miscarriages	_____
Premature births	_____	live births	_____	living children	_____

BIRTH DATE	TYPE OF DELIVERY	WEEKS PREGNANCY	BIRTH WEIGHT	BABY'S SEX

Pregnancy complications: diabetes ☐ high blood pressure ☐ other _____

History of depression before or after pregnancy? Yes ☐ No ☐ _____

GYN HISTORY

How old were you when you had your first period? _____

Are your cycles regular/monthly? Yes ☐ No ☐

How many days does your period last? _____

If in menopause, at what age did it occur? _____

Years of hormone replacement therapy? _____

Are you currently sexually active? Yes ☐ No ☐

If not, have you ever been sexually active? Yes ☐ No ☐

Do you currently have a partner? Yes ☐ No ☐ Partner's gender _____

How long have you been in this relationship? _____

How many lifetime sexual partners have you had? _____

At what age was your first intercourse? _____

Have you ever been sexually abused, threatened or hurt by anyone? _____

Are you experiencing any sexual problems? _____

When was your last pap smear? _____

Have you had any abnormal pap smears? Yes ☐ No ☐ when? _____

Have you been told you have HPV? Yes ☐ No ☐ when? _____

Have you had any treatments for abnormal pap smears? Yes ☐ No ☐ repeat pap colposcopy biopsy

Have you received HPV vaccine? Yes ☐ No ☐ date _____

Have you ever had ovarian cysts? Yes ☐ No ☐

Have you been told you have fibroids of the uterus? Yes ☐ No ☐

Have you ever been treated for any sexually transmitted infections? Yes ☐ No ☐

☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Condyloma ☐ PID

Have you ever been tested for HIV? YES ☐ NO ☐ Date of last test? _____ Result? Neg ☐ Pos ☐

Current birth control

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Patch
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Ring

Past birth control

☐ None ☐ Timing ☐ Condoms ☐ Diaphragm ☐ Birth control pills ☐ Patch
☐ Implants ☐ Depo Provera ☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Ring

Have you ever had a yeast infection? Yes ☐ No ☐ Chronic? Yes ☐ No ☐

Have you ever been treated for a vaginal bacterial infection (bacterial vaginosis)? Yes ☐ No ☐ Chronic? Yes ☐ No ☐

Do you ever have problems with urinating such as infections, frequency, loss of urine, blood in your urine? Yes ☐ No ☐

If yes, please explain _____

When was your last mammogram? _____
Have you had any abnormal mammograms? Yes ☐ No ☐ _____
Have you had any breast biopsies? Yes ☐ No ☐ If yes, result _____
Do you do breast self examination? Yes ☐ No ☐

HEALTH MAINTENANCE

Procedure	date	results
Last bone density		
Last cholesterol		
Last colonoscopy		

MEDICAL HISTORY

Arthritis	yes ☐	no ☐	_____
Asthma	yes ☐	no ☐	_____
Chronic lung disease	yes ☐	no ☐	_____
Cancer	yes ☐	no ☐	_____
Diabetes	yes ☐	no ☐	_____
Eye disease	yes ☐	no ☐	_____
Heart disease	yes ☐	no ☐	_____
Hypertension	yes ☐	no ☐	_____
Kidney disease	yes ☐	no ☐	_____
Liver disease	yes ☐	no ☐	_____
Psychiatric disorder	yes ☐	no ☐	_____
Seizures/epilepsy	yes ☐	no ☐	_____
Stomach/intestinal disease	yes ☐	no ☐	_____
Stroke	yes ☐	no ☐	_____
Thyroid disease	yes ☐	no ☐	_____
Other			_____

SURGICAL HISTORY

List any surgeries you have had and the approximate date
Example: tonsillectomy, appendectomy, gallbladder, tubal ligation, breast surgery/biopsy, laparoscopy

_____

_____

_____

_____

Have you had a blood transfusion? Yes ☐ No ☐ if yes, when_____

FAMILY HISTORY

list any MEDICAL CONDITIONS of your relatives

Mother living/deceased _____

Father living/deceased _____

Siblings _____

	☐☐		Relationship to you
Diabetes	yes ☐	no ☐	_____
Hypertension	yes ☐	no ☐	_____
Thyroid disease	yes ☐	no ☐	_____
Cancer			
Breast	yes ☐	no ☐	_____
Ovarian	yes ☐	no ☐	_____
Colon	yes ☐	no ☐	_____
Other			_____
Psychiatric illness	yes ☐	no ☐	_____
Osteoporosis	yes ☐	no ☐	_____
Other	yes ☐	no ☐	_____

SOCIAL HISTORY

Occupation _____

Marital status single ☐ married ☐ separated ☐ divorced ☐ widowed ☐

Children _____

Pets _____

Tobacco	yes☐	no☐	quit ☐	#cigarettes/day _____	#years	_____
Alcohol	yes☐	no☐	quit ☐	#drinks per day/week _____	type	_____
Drugs	yes☐	no☐	quit ☐	_____		
Exercise	yes☐	no☐	☐	#times/week _____	type	_____

Health care proxy yes☐ no☐

Seat belt use yes☐ no☐

MEDICATIONS (including over the counter medications and supplements)

Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any medications or foods that you are **ALLERGIC** to (and the reaction):

_____	_____
_____	_____

REVIEW OF SYSTEMS — Please circle all that are applicable (within the last 6-12 months)

CONSTITUTIONAL
☐ Negative
☐ Fever
☐ Chills
☐ feeling poorly
☐ feeling tired
☐ recent weight gain
☐ recent weight loss

EYES
☐ Negative
☐ Eye Pain
☐ Wearing glasses
☐ spots before eyes
☐ vision changes
☐ dry eyes
☐ itchy eyes

EAR/NOSE/THROAT
☐ Negative
☐ Earaches
☐ Loss of hearing
☐ nose bleeds
☐ sinus problems
☐ sore throat
☐ dental problems

CARDIOVASCULAR
☐ Negative
☐ Chest pain
☐ Palpitations
☐ heart rate is fast
☐ heart rate is slow
☐ leg swelling (edema)

RESPIRATORY
☐ Negative
☐ Shortness of breath
☐ Wheezing
☐ cough
☐ dyspnea (shortness of breath) on exertion
☐ shortness of breath with lying flat (orthopnea)
☐ respiratory distress in sleep (PND)

GASTROINTESTINAL
☐ Negative
☐ Abdominal pain
☐ Vomiting
☐ Nausea
☐ constipation
☐ diarrhea
☐ early satiety
☐ heartburn
☐ black stool (melena)
☐ maroon colored stool (hematochezia)

OB/GYN GU
☐ Negative
☐ Frequency
☐ Nocturia
☐ Dysuria
☐ blood in urine
☐ cloudy urine
☐ odor in urine
☐ incomplete emptying of bladder
☐ stress incontinence
☐ urge incontinence

OB/GYN
☐ Negative
☐ Abnormal bleeding
☐ Irregular menses
☐ Pain with menses
☐ Pain with intercourse
☐ Anorgasmia
☐ vulvar itching
☐ midcycle bleeding
☐ post coital bleeding
☐ vulvar pain
☐ decreased libido
☐ vaginal itching
☐ pelvic pain
☐ vaginal dryness
☐ vaginal discharge
☐ vaginal odor

MUSCULOSKELETAL
☐ Negative
☐ Arthralgia (joint pain)
☐ joint swelling
☐ joint stiffness
☐ limb pain
☐ limb swelling

INTEGUMENTARY (SKIN)
☐ Negative
☐ Acne
☐ Breast discharge
☐ itching
☐ change in a mole
☐ breast pain
☐ breast lump

NEUROLOGICAL
☐ Negative
☐ Confused
☐ Memory problems
☐ dizziness
☐ headaches/migraines
☐ limb weakness
☐ difficulty walking

PSYCHIATRIC
☐ Negative
☐ Suicidal
☐ Sleep disturbances
☐ anxiety
☐ depression
☐ change in personality
☐ emotional problems

ENDOCRINE
☐ Negative
☐ Hair loss
☐ Hot flashes
☐ Heat/cold intolerance
☐ muscle weakness
☐ deepening of the voice
☐ feeling weak
☐ dry skin

HEMATOLOGY/IMMUNOLOGY
☐ Negative
☐ Easy bleeding
☐ seasonal allergies
☐ swollen glands
☐ easy bruising

For Patients with Commercial Insurance, Medicaid, or Medicare with a secondary plan

Personal & Family Cancer History

Name: _____ Date: _____ Date of Birth: _____ Age: _____

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides.** Specify which relatives were affected and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**
2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

CANCER HISTORY			You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	**Yes**	BREAST CANCER diagnosed age 49 or younger					
No	**Yes**	OVARIAN CANCER at any age					
No	**Yes**	Ashkenazi Jewish heritage with a BREAST CANCER at any age					
No	**Yes**	3 or more BREAST, PROSTATE, and/or PANCREATIC CANCERS on one family side, any ages					
No	**Yes**	MALE BREAST CANCER at any age					
No	**Yes**	2 or more COLON CANCERS on a family side, at least one under 50					
No	**Yes**	3 or more COLON and/or UTERINE CANCERS on a family side, any ages					

Patient Signature _____

OFFICE USE ONLY Patient offered genetic testing: Yes / No Accepted / Declined Provider Initials: _____