New Patient History

Name:__________________________Age_________DOB:____________Today's Date:___________________

Reason for todays visit:____

Last period began on __/__/__

Have you noticed anything different about your periods? ☐ Yes ☐ No

If yes, Please explain____

Current Medications: ☐ None, or____

Allergies: ☐ Latex ☐ Seasonal ☐ Food ☐ Medication______________________________Reaction__________

PAST MEDICAL HISTORY	YES	NO	FAMILY	DESCRIBE
Thyroid problem	☐	☐	☐	______________________________
Heart disease	☐	☐	☐	______________________________
High blood pressure	☐	☐	☐	______________________________
Stroke	☐	☐	☐	______________________________
Heart Attack	☐	☐	☐	______________________________
High Cholesterol	☐	☐	☐	______________________________
Lung disorder (COPD,ASTHMA)	☐	☐	☐	______________________________
Breast problems	☐	☐	☐	______________________________
Jaundice, hepatitis, or liver disorder	☐	☐	☐	______________________________
Stomach, bowel, or gallbladder disorder	☐	☐	☐	______________________________
Kidney or bladder problems	☐	☐	☐	______________________________
Sexual problems	☐	☐	☐	______________________________
Anemia or Blood disorder	☐	☐	☐	______________________________
Blood transfusion	☐	☐	☐	______________________________
Diabetes	☐	☐	☐	______________________________
Cancer	☐	☐	☐	______________________________
Birth defects	☐	☐	☐	______________________________
Bipolar, depression, schizophrenia	☐	☐	☐	______________________________
Epilepsy or seizure disorder	☐	☐	☐	______________________________

Auto immune disorder (lupus etc)	☐	☐	☐	___________________________
Drug or alcohol abuse	☐	☐	☐	___________________________
Other	☐	☐	☐	___________________________

SURGERIES

Mo/Yr Procedure (Tonsils,dental,c-section,cosmetic,tubal ligation etc) Complication? Yes or No

____

____

____

____

MENSTRUAL HISTORY

Age when your period started?_____

If **postmenopausal,** age at time of menopause_____

How far apart are your period's?___________

# of days menstrual flow lasts___________

Flow: Light___ med___ heavy__

# of pads or tampons used on heaviest day of menses___

Periods: Regular____ Irreg.___ Absent____

Cramping: None____ Mild____ Severe_____

Medication taken for menstrual cramps:

____

CONTRACEPTIVE HISTORY

Pill **PAST PRES** Patch **PAST PRES**

IUD **PAST PRES** Condom **PAST PRES**

Tubal **Past PRES** Diaphragm **PAST PRES**

List any issue or current problems with contraception**:**

____

____

GYNECOLOGY HISTORY

Abnormal Pap smear	**YES**	**NO**
Leep or Cryo Therapy	**YES**	**NO**
Hernia Repair	**YES**	**NO**
Staph/MRSA infection	**YES**	**NO**
Ovarian Cysts	**YES**	**NO**
Hysterectomy	**YES**	**NO**
Endometriosis	**YES**	**NO**
Vaginal infection	**YES**	**NO**
Loss of urine with coughing	**YES**	**NO**
Bladder repair	**YES**	**NO**
Breast lump or biopsy	**YES**	**NO**
Bartholin Gland Cyst/Removal	**YES**	**NO**
Urinary Tract infection	**YES**	**NO**
Problem with excess hair	**YES**	**NO**

Additional comments**:**___________________

Have you ever had problems becoming pregnant?

Yes____ No______

SEXUAL HISTORY

Age of 1st intercourse____

# of sexual partners-total___ current___

Sexually Active? Yes___ No____

Painful intercourse: Yes ___ No ____

Libido (sex drive): Good ___ Average___ Poor ___

Spotting or bleeding after intercourse Yes___ No ___

Any history of sexually infection(s) YES or NO

Type:___________________________________

Treatment when?________________________

Date of last pelvic exam___________________

Date of last Pap smear____________________

Result**: Normal_____ Abnormal______**

If abnormal what treatment________________

Have you ever had a **Colonoscopy?** __________

Have you ever had a **Bone density test?______**

Have you ever or do you presently take hormone for hot flashes or post-menopausal symptoms?

Yes___ NO_____

How often do you do **self-breast exams?**_________

Have you had a **mammogram**, YES__ NO___

When was the last one__________________?

OBSTETRICAL HISTORY

Please list the number of times Pregnant_____

Miscarriages ________________

Abortions___________________

Ectopic Preg.________________

Living Children________________

DELIVER HISTORY:

MO/YR	**Baby WT**	**SEX**	**WKS PG**	**VAG/C-SEC**	**Complications?**

Social History:

Occupation____________________

Sleep: Good_______ Problem_______ Taking Sleep aid_______

Smoker_____Former______Never Smoked______ #______per day

Exercise? YES or NO

Abuse and Violence- Are currently in a situation where you are physically, emotionally, or sexually abused? Yes or NO Have you ever been in a situation where you are physically, emotionally, or sexually abused? Yes or NO