New Patient Medical History

Name: _____ **Age:** _____ **Date**: _____

Reason for Today's visit: _____

Medical History: Have you or anyone in your family ever had any of the following:
(If family member, please indicate relationship, i.e. Mother, father, sibling, grandparent, etc.)

	You	Your family		You	Your family
High blood Pressure			Anemia or Blood disorders		
Diabetes			Blood transfusions		
Heart problems			HIV/AIDS		
Lung problems, asthma/TB			Blood clots in legs or lungs		
Stroke/TIA			Eating disorders		
Thyroid problems			Nervous disorders, depression/anxiety		
Stomach problems, IBS/GERD			Breast Cancer		
Unusual headaches/Migraines			Ovarian Cancer		
Seizures			Colon Cancer		
Fainting spells			Uterine Cancer		
Breast problems			Pancreatic cancer		
Kidney or Bladder problems			Other:		

Surgeries: _____

Gynecological History:
Age of first period: _____
Frequency between periods: _____
Duration of period: _____
Pain/cramping: _____
Date of last Pap +/- HPV: _____ Results: _____
Date of last Mammogram: _____
Where? _____ Result: _____

Any history of: Date:
□ Ovarian cysts _____
□ Uterine fibroids _____
□ Abnormal Pap smear/HPV positive _____
□ Herpes _____
□ Chlamydia _____ □ Genital warts _____
Other _____

Did you receive the HPV vaccine?
If so, how many? _____

Are you sexually active? □ Yes □ No
□ with women. □ with men.
Type of **current** birth control (if indicated): _____
Number of sexual partners in past year: _____

Obstetrical History (including Stillborn):
Number of Vaginal Deliveries: _____
Number of C/S: _____
Any Complications? _____
Miscarriages: _____
Terminations: _____
Ectopic/Tubal pregnancies: _____

If you are postmenopausal:
Any vaginal bleeding since menopause? □ Yes □ No
Have you taken systemic hormones □ Yes □ No
If so, what and when? _____
Have you used vaginal estrogen? □ Yes □ No
Who is following your bone density? _____
When/Results? _____

Allergies: _____

Current Medicines: _____
_____
_____
_____

Do you Smoke? □ Yes □ No
packs per day: _____

Do you drink any alcohol? □ Yes □ No
drinks per day: _____

Exercise? □ Yes □ No
Type and frequency: _____
Occupation: _____

How did you hear of our office? _____