NEW PATIENT INFORMATION

NAME:_____________________________ DOB:__________ TODAY'S DATE:_________

Reason for today's visit:

Reproductive History

Last Menstrual period_______ Age of first menstrual period_____ Age of menopause_____ Hormones Y N

Menstrual frequency__________ How many days of bleeding__________ Tampons or pads___________

Abnormal bleeding Y N Pain with periods Y N Fibroids Y N Ovarian cysts Y N

Sexually active Y N Age at first intercourse______ # of partners_____ Pain with intercourse Y N

Birth Control Y N Birth control method: condoms pills Nuvaring IUD sterilization Depo

History of sexually transmitted diseases Y N History of sexual or physical abuse Y N

Do you know how to perform breast self exams Y N

Date of last pap smear__________ Results__________ History of abnormal paps________________________

Date of last mammogram________ Results__________ History of abnormal mammograms_________________

Obstetric History (Please list all pregnancies, including miscarriages, ectopic pregnancies or elective terminations)

______	______	______	______	______	______	______	______
#pregnancies	#full term	#preterm	#ectopics	#miscarriages	#elective terminations	#multiples	#living

Date	Weight	Vaginal/C-Section	Preterm Labor	Male/Female	Complications

Medications (Prescription and over the counter)

Drug Name	Dosage	Reason

Family History

Has anyone ever had:		Family member (maternal/paternal)	Age ______ at onset
Breast cancer	Y N		
Ovarian cancer	Y N		
Colon cancer	Y N		
Uterus cancer	Y N		
Cervical cancer	Y N		
Heart disease	Y N		
Hypertension	Y N		
Stroke	Y N		
Diabetes	Y N		

Allergies

Latex Y N

Seasonal Y N

Medications (please list medication and reaction):

____

____

____

Surgical History

Hysterectomy Y N Abdominal, vaginal, laparoscopic?

Ovaries removed Y N

Other surgeries	Date	Reason

Past Medical History

Arthritis	Y N
Hypertension	Y N
Stroke	Y N
Hypercholesteremia	Y N
Thyroid disease	Y N
Autoimmune disease	Y N
Blood disorders	Y N
Osteoporosis	Y N
Cancer	Y N
Diabetes	Y N

Social History

Relationship status: Single___ Married___ Divorced___ Widowed___

Alcohol use: Never___ Drinks/week_____ OR Drinks/month_____

Tobacco use: Never used___ Current packs/day___ Previously used___

Drug use: Never____ Type/Frequency____________________________

Exercise: Y N Type_____________ Frequency_________