NEW PATIENT HISTORY

Date: _____

Name: _____ Age: _____

What is the reason for your visit today? _____

Pregnancies: _____ Deliveries: _____ Miscarriages: _____ Abortions: _____ Living Children: _____

Last Menstrual Period: _____ How often are your periods? _____

Your age at your first period? _____ Do you have any problems/pain with periods? _____

How many days do your periods last? _____ Are you trying to become pregnant? _____

How long have you been trying to become pregnant? _____ Do you think you may be pregnant now?

Did your mother us the drub D.E.S. or hormones while pregnant with you? _____

Type of present contraception? _____ Do you want to change? (forms of contraception? _____

Type of past contraception? _____ Date of last pap smear? _____

Results of last pap smear? _____ Have you ever had an abnormal pap smear?

If you had an abnormal pap smear, what was the treatment? _____

Are you sexually active? _____ Do you have any difficulties or discomfort? _____

Have you ever had a mammogram? _____ If so, when (date)? _____

Have you ever been turned down as a blood donor? _____ If so, for what reason? _____

List all currently used medications: (Including all herbal products)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all allergies to medications:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Surgeries: (Type)
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Please list previous pregnancies, including miscarriages and/or terminations:

Year	Sex	Weight	Complications

Name: _____

GYNECOLOGICAL HISTORY:

With respect to your female organs, do you currently have……(circle all that apply)

Vaginal Infections	Pain with Intercourse	Persistent low back pain
Vaginal Discharge	Pain with Urination	Difficult bowel movements
Herpes Infection	Infection of the tubes or ovaries	Breast lumps, pain, discharge, or cancer
Loss of urine with coughing, laughing, or exercise	Gonorrhea, Syphilis, or Chlamydia	Pelvic pain or pressure

PAST HISTORY:

Have you ever had……(circle all that apply)

German Measles	Heart Attack	Asthma	Glasses or Contacts
Migraine Headaches	Heart Murmur	Kidney Stone	Pneumonia
Blood Transfusions	Rheumatic Fever	Kidney Infection	Dentures
Tuberculosis	Other Heart Disease	Other Kidney Disease	Ulcers
Thyroid Trouble	High Blood Pressure	Arthritis	Hepatitis
Breast Tumor	Intestinal Bleeding	Neurologic Disease	Paralysis
Diabetes or Abnormal blood sugar	Inflammation/Clotting of Leg Veins		

SOCIAL HISTORY:

Do you drink alcohol? _____ If yes, estimate number of drinks per week? _____

Do you smoke? _____ How many packs per day? _____

FAMILY HISTORY: Is there a member of your family with a history of any of the following?

1. Diabetes _____ Who? _____
2. Heart Disease _____ Who? _____
3. High Blood Pressure _____ Who? _____
4. Kidney Disease _____ Who? _____
5. Colon Cancer _____ Who? _____
6. Breast Cancer _____ Who? _____
7. Twins _____ Who? _____
8. Mental Retardation _____ Who? _____
9. Osteoporosis _____ Who? _____
10. Congenital (Inherited Disease) _____ Who? _____
11. Ovarian Cancer _____ Who? _____