New Patient History

Date:________________

Name:____

Age___________ Primary MD :________________

Insurance___________________________

Required Lab: Labcorp Quest LabOne Renown

Required Radiology_____________________________

ALLERGIES to medications:______________________

___________________________Allergy to Latex: Y N

MEDICATIONS: _______________________________

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REASON FOR VISIT:_____________________________

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Gynecologic History: Please circle or complete:

Gyn	None	1st day of last period________________ Last pap__________ Last mammo______ Last colonscopy?_____________________ Type of birth control?____________________
Menses	None	Regular Irregular Severe cramping >7days Excess bleeding Age of 1st period?__________
STD/Infection	None	Warts/condyloma HPV Herpes Chlamydia Gonorrhea PID
Other history	None	Endometriosis Ovarian cysts Fibroids PMS DES exposure Pain w/sex Bleeding w/sex Falling out feeling/pressure
Menop	None	Hot flushes Night sweats Vaginal dryness
Pap Smears	Normal	Never Abnormal HPV Dysplasia Colposcopy Cryo Laser Leep Cone biopsy
Sexual history	Never	Age of 1st intercourse_______ Sexual Preference: Male Female Number of partners: <5 >5
OB history	None	# of preg ______ # of deliveries________ # of miscarriage _____# of abortions _______ C-sections Complications

Surgical History: What surgeries have you had?

Tonsillectomy	GYNECOLGIC: Hysterectomy: Vaginal
Breast biopsy	Abdominal Laparoscopic
Appendectomy	Ovaries removed: D&C/hysteroscopy
Gallbladder	Ovarian cyst removed Laparoscopy
Bladder repair	Tubal ligation C-section
Orthopedic	Cosmetic
Other:____________________	

Your Medical History:

High blood pressure		High cholesterol	Seizure
Asthma	Heart disease	Hypothyroid	Hyperthyroid
Lung DZ	Heart attack	Liver problems	Hepatitis
Migraines	DVT (blood clots)	Bleeding disorder	Stroke
Diabetes: AODM or IDDM		Depression/anxiety	
Cancer: What kind?_____________________________________			
OTHER ILLNESS____			

Family History

Problem	Relationship:
High blood pressure	
Stroke	
Heart Dz	
DVT/Blood clots	
Diabetes	
Cancer: Breast	
Ovarian	
Uterine	
Colon	
Other:	
Osteoporosis	

Social History

Habits:

Tobacco: None Quit

Yes: How many?________

Alcohol: Never Social

Recovering

____

Marital Status: Single

Married Divorced Widowed

Steady partner

Occupation:

____

REVIEW: Circle CURRENT PROBLEMS ONLY.

Urinary	None	Incontinence Frequency Urgency Blood in urine Pain w/urination Falling out feeling Incomplete emptying
Breast	None	Pain Discharge Lump
GI	None	Nausea/vomiting Abd. Pain/cramping Diarrhea Constipation Bloody/black stools Bloating
Other	None	Unexplained weight gain Fatigue Headaches Fainting Wt loss

Other comments:___________________________________

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