

New Patient History

Name: _____ Date of Birth: _____ Today's Date: _____ Sex: _____

Allergies (medication, shellfish, metals, foods): _____

Reason for visit today: _____

Past Medical History

Breast cancer
 Colon cancer
 Ovarian cancer
 Other cancer
 Asthma/COPD
 Diabetes
 Thyroid problems
 Osteoporosis
 High blood pressure
 High cholesterol
 Heart attack or stroke
 Anemia
 Blood clots
 Blood clotting disorder

Heart valve problems
 Heart murmur
 Migraine headaches
 Seizure disorder
 Other neurological disorder
 Breast problems (cysts, benign lumps)
 Eye problems (other than glasses)
 Kidney problems
 Reflux/heartburn
 Crohn's or ulcerative colitis
 Celiac disease
 Gallbladder problems/removal
 Liver problems (fatty liver disease, cirrhosis)
 Depression
 Anxiety

Past surgeries/hospitalizations:
Daily medications/supplements:

Family History (parent or sibling)

(M-mother, F-father, B-brother, S-sister)

Breast cancer
 Colon cancer
 Ovarian cancer
 Other cancer
 Diabetes
 Osteoporosis
 Thyroid problems
 High blood pressure
 High cholesterol
 Heart attack or stroke
 Heart disease
 Blood clotting disorder
 Crohn's or ulcerative colitis

Social History

Relationship status: single married long-term/domestic partner
Sexual identity: straight gay lesbian bisexual transgender
Are you sexually active?
With: males females both
Do you have adopted or foster children? If yes, how many? _____

Current occupation:
Religious/spiritual beliefs:

Menstrual History (if applicable)

First day of last period: ___/___/___
Age of first period: _____
Duration of bleeding: _____
Frequency of periods: _____

Amount of bleeding: Heavy medium light
Severe cramping with periods: no yes
Bleeding between periods: no yes

Menopause (if applicable)

Age of last period: _____
Menopausal symptoms: hot flashes vaginal dryness decreased libido depression anxiety
Bleeding since menopause: no yes
Hormone replacement therapy: no yes

-Continue on back-

Gynecological History (if applicable)

Date of last Pap test: _____
Have you ever had an abnormal Pap? _____
If yes, did you have a colposcopy? _____
LEEP? _____ Cryotherapy? _____

Please check if you have or have had any of the following:
 Infertility Urinary incontinence
 Frequent vaginal infections Endometriosis
 Polycystic ovaries (PCOS) Ovarian cysts
 Pelvic inflammatory disease Pelvic pain

Male Genitourinary History (if applicable)

Please check if you have or have had any of the following:
 Painful urination Enlarged prostate
 Difficulty achieving or maintaining erection Sexually transmitted infection
 Frequent urination Decreased libido

Obstetric History (if applicable)

Please include number of:
 Full-term pregnancies Still births Ectopic pregnancies
 Pre-term births Miscarriages Number of living children
 Caesarian births Abortions

Pregnancy complications:

Labor and delivery complications:

Health Maintenance

How would you rate your overall health?

Excellent
 Good
 Fair
 Poor

Do you exercise regularly?

Yes (please indicate type, duration and frequency) _____
 No regular exercise

How would you rate your nutrition?

Excellent
 Good
 Fair
 Poor

Do you drink alcohol?

Yes, how much per day or week? _____
 No

Please check all that apply regarding dietary history:

Vegetarian/vegan (circle one)
 Skip breakfast or other meals
 Eat fast-food regularly (more than twice a week)
 Drink cola/diet cola (circle one)

Do you use tobacco products?

Yes, Type: _____ Amount per day: _____
 No, I do not use tobacco products
 Former tobacco use
 I would like information about quitting

Please check all vaccines or childhood diseases:

Tetanus (past 5 years) Hepatitis B
 Measles Mumps/ Rubella HPV
 Chicken pox/vaccine

Signature _____

Provider

Signature _____

Would you like to communicate via email for brief questions or concerns?

Yes, (must read and sign email consent)

Email _____

No, I do not wish to communicate via email