WOMEN PARTNERS
IN OB/GYN

New Patient History

Name: _____ **Date of Birth**: _____

Reason for Visit: Annual Exam Problem: _____

PAST MEDICAL HISTORY

	Yes	If yes, please list dates and type of problem:
Alcoholism		
Anemia		
Anxiety		
Arthritis/Joint problems		
Asthma		
Back problems		
Bladder problems		
Blood clots in veins		
Blood transfusions		
Bowel problems		
Cancer		
Chronic lung disease		
Depression		
Diabetes		
Endometriosis		
Fibroids		
Fracture		
Glaucoma		
Mitral valve prolapse		
Heart trouble		
Hepatitis/Liver disease		
High blood pressure		
High cholesterol		
High triglycerides		
Kidney infections/disease		
Migraines		
Need antibiotics for prophylaxis		
Seizure Disorder		
Stroke		
Thyroid Disorder		
Other:		

SCREENING TESTS: (please list most recent results and where performed)
Last pap smear (date/results/M.D.)_____
Ever abnormal? Yes No Details:_____
Cholesterol_____ Thyroid_____
Blood count/ Hematocrit_____
Mammogram: _____
Bone density: _____
Colonoscopy: _____
Flu vaccine (year)_____Pneumonia vaccine (year)_____Hepatitis B vaccine_____

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PAST SURGICAL HISTORY

Year	Illness or Operation	Complications?

MEDICATIONS (prescription and non-prescription medications, vitamins, birth control, herbs etc)

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

ALLERGIES (drugs, foods, latex) REACTION

FAMILY HISTORY (please fill in the **age of onset** of each condition)

	Mother	Father	Sister	Brother	Mother's mother	Mother's father	Father's mother	Father's father	Aunt
Blood clots in veins									
Bleeding disorder									
Stroke									
Diabetes									
Heart disease									
High blood pressure									
Osteoporosis									
Thyroid disease									
Dementia									
Breast cancer									
Ovarian cancer									
Colon cancer									
Other cancer									
Psychiatric Problems									
Other Diseases									

<u>Age/State of Health</u>

Mother: _____ Father: _____

Spouse: _____ Children: _____

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GYNECOLOGIC HISTORY

Age periods began (menarche):_____ Age periods ended (menopause):_____

If still having periods: Last menstrual period (1st day):_____

Days between periods_____ Length of periods_____

Flow: Light Moderate Heavy Clots: Yes No

# of tampons/day____# of pads/day____

Please list birth control type _____Years used:_____

If menopausal, are you on hormone replacement? Yes No

Ever used hormone replacement? Name: _____ Years used _____

Have you had the HPV vaccine (Gardasil)? Yes No

REPRODUCTIVE HISTORY

	Number		Number
Total Pregnancies		Miscarriages	
Full term births		Ectopics	
Premature births (less than 37wks)		Multiple birth (twins, etc.)	
Abortions/Terminations		Living children	

On the chart below, please fill in answers for each pregnancy including miscarriages:

	Mo./ Day/ Yr.	Weeks Pregnant	Length of Labor	Birth weight	Sex	Delivery Type	Epidural (Y/N)	Preterm labor (Y/N)	Complications	Hospital/ Doctor
1										
2										
3										
4										
5										

SOCIAL HISTORY

Occupation: _____

Ethnicity: _____

Marital Status: single married divorced domestic partner widowed

Religious Preference: Christian Jewish Muslim Hindu Jehovah's witness Other

Tobacco Use: Cigarettes: Never Quit (date)_____

Current smoker ____packs/day x ____yrs

Alcohol Use: No Yes _____ drinks per week (beer wine liquor)

Is alcohol a concern for you or for others? yes no

Drug Use: No Yes _____ Have you ever used needles No Yes

DES exposure: Yes No

Infection Risk: Are you sexually active? Yes No

History of STD: Chlamydia Gonorrhea Herpes Syphilis HIV PID HPV

Safety: Do you use seat belts consistently? Yes No

Is violence at home a concern for you? Yes No

Have you ever been abused? Yes No

Exercise: Do you exercise regularly Yes No What kind of exercise_____

How often? _____How long?_____ If not, why?_____

Diet: How do you rate your current diet? Good Fair Poor

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REVIEW OF SYSTEMS: (please check all that apply to you today)

	Yes		Yes
Constitutional		**Gynecological**	
Fatigue		Vaginal discharge	
Fever		Irregular bleeding	
Chills		Painful periods	
HENT		Painful intercourse	
Headaches		**Integumentary**	
Sore throat		Genital sores/bumps	
Breasts		Unexplained lumps	
Breast lumps		Acne	
Nipple discharge		**Musculoskeletal**	
Breast pain		Back Pain	
Cardiovascular		Joint Pain	
Chest Pain		**Endocrine**	
Heart Palpitation		Weight loss	
Respiratory		Weight gain	
Wheezing		**Psychological**	
Cough		Anxiety	
Shortness of breath		Depression	
Gastrointestinal		Difficulty sleeping	
Abdominal pain		Panic attacks	
Nausea		**HEME/Lymph**	
Vomiting		Easy bruising	
Constipation		Easy Bleeding	
Diarrhea		**Allergic/Immunological**	
Blood in stool		Hay Fever	
Change in bowel habits		Sinus congestion	
Genitourinary			
Painful urination			
Leaking urine			
Urinary urgency			
Urinary frequency			
Blood in urine			
Nocturia (urinating 2 or more times/night)			