



Women Partners
in OB/GYN

New Patient History

Name: _____

Date of Birth: _____

Reason for Visit: Annual Exam Problem: _____

PAST MEDICAL HISTORY

	Yes		Yes
Cardiovascular		Musculoskeletal	
High blood pressure		Arthritis	
High cholesterol		Osteoporosis/Osteopenia	
Mitral valve prolapse		Fracture	
Stroke or TIA			
Blood clots in vein or in lungs		Neurological	
		Migraines (w/ or w/out visual changes)	
Respiratory		Multiple sclerosis	
Asthma		Parkinson's disease	
COPD		Seizure disorder/epilepsy	
		Vision/hearing problems	
Endocrine/Metabolic			
Diabetes (Type 1 or Type 2)		Psychiatric/Behavioral	
Thyroid disorder (hypo or hyperthyroid)		Anxiety	
PCOS		Depression	
		ADHD	
Gastrointestinal		Substance use disorder	
Irritable bowel syndrome (IBS)			
Inflammatory Bowel Disease (Chron's/UC)		Gynecological	
Liver Disease/Hepatitis		Fibroids	
		Endometriosis	
Urinary		Recurrent pregnancy loss	
Kidney disease		Infertility	
Kidney infections/stones		Genital herpes	
Urinary incontinence			
Recurrent urinary tract infections		Cancer:	
Hematology/Immune		Other:	
Anemia			
Clotting disorders			
Autoimmune disease (lupus, sjogrens, RA, etc)			

PAST SURGICAL HISTORY

Year	Illness or Operation	Complications?

(Please complete both sides of each page)

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

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

ALLERGIES (drugs, foods, latex)

Allergen	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									
High blood pressure									
Osteoporosis									
Thyroid disease									
Dementia									
Breast cancer									
Ovarian cancer									
Colon cancer									
Other cancer									
Psychiatric Problems									
Other Diseases									

If applicable, please provide insight on the health of your household/family:

Children (ages/state of health): _____

Spouse (state of health): _____

(Please complete both sides of each page)

GYNECOLOGIC HISTORY

Age periods began (menarche): _____

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 _____

of times empty menstrual cup/day _____

Pain with periods: None Mild Moderate Severe

Do you have sex? Yes No

If yes, do you have sex with: Men Women Both

Have you had a new sexual partner since your last exam? : Yes No

How do you prevent pregnancy? _____

History of STD: Chlamydia Gonorrhea Herpes Syphilis HIV PID HPV

Age periods ended (menopause): _____

If menopausal:

Are you on hormone replacement therapy? Yes No

Ever used hormone replacement? Name: _____ Years used _____

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										

(Please complete both sides of each page)

PREVENTATIVE HEALTH

	Date/results/location
Last pap smear:	
Ever abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No Colposcopy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other cervical procedures?	<input type="checkbox"/> LEEP <input type="checkbox"/> Cryosurgery <input type="checkbox"/> Cold knife cone surgery
Last wellness labs:	
Abnormal results?	<input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood sugar <input type="checkbox"/> Anemia <input type="checkbox"/> Other:
Mammogram	
Colonoscopy (45 and up)	
Bone density scan (menopause)	
Vaccines (year received)	HPV (Gardasil):

SOCIAL HISTORY

Occupation: _____

Ethnicity: _____

Marital Status: Single Married Divorced Separated
 Engaged Domestic Partner Widowed

Religious Preference: Christian Jewish Muslim Hindu
 Jehovah's Witness Other: _____ Prefer not to answer

Abuse Screen: None Physical abuse Sexual abuse Emotional abuse

Tobacco/Cigarettes Use: Never Quit (date) _____ Current, ___ packs/day, X ___ yrs

Alcohol Use: No Yes, # _____ drinks per week (beer wine liquor)
 Is alcohol use a concern for you or others? No Yes

Drug Use: No Yes, If so, what drug(s) _____

Exercise: Do you exercise regularly? No Yes
 If no, why not? _____

If yes, what kind of exercise _____
 How often? _____ How long? _____

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

(Please complete both sides of each page)

REVIEW OF SYSTEMS:

(Please check all that apply to you **TODAY**)

	Yes		Yes
Constitutional		Genitourinary	
Headache		Painful urination	
Fatigue		Leaking urine	
Fever/chills		Urinary urgency	
Weight gain		Urinary frequency	
Weight loss		Blood in urine	
		Urinating 2 or more times/night	
Cardiovascular			
Chest pain		Gynecological	
Heart palpitation		Vaginal discharge	
		Vaginal irritation/itching	
Respiratory		Vaginal odor	
Cold/allergy symptoms		Vaginal dryness	
Wheezing/cough		Irregular bleeding	
Shortness of breath		Painful periods	
		Painful sex	
Breast		Pelvic pain	
Breast lumps		Genital sores/bumps	
Nipple discharge		Sexual function concerns	
Breast pain			
		Peri/menopause symptoms	
Musculoskeletal		Hot flashes	
Back Pain		Night sweats	
Joint Pain		Difficulty sleeping	
		Decreased libido	
Skin		Mood changes	
Rash/sores/bumps		Brain fog	
Acne			
		Psychological	
Gastrointestinal		Anxiety	
Abdominal pain		Depression	
Nausea		Difficulty sleeping	
Vomiting		Panic attacks	
Constipation			
Diarrhea		Other:	
Blood in stool			
Change in bowel habits			

(Please complete both sides of each page)