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New Patient History

Name _____ **Your Age** _____ **Today's Date** _____

First Day of Last

Occupation_____ **Menstrual Period** _____

REASON FOR VISIT TODAY _____

_____

HEALTH QUESTIONS YOU WOULD LIKE TO ASK TODAY _____

_____

MEDICAL HISTORY

Have you ever been **HOSPITALIZED**? Please include accidents, medical problems, pregnancies, and all **OPERATIONS**. Please give dates.

_____

_____

Do you take any **MEDICATIONS**? Please include prescription and non-prescription drugs. Please give dosages.

_____

Do you take any **SUPPLEMENTS**? Please include dosage if known.

ALLERGIES to Medications?

Have you ever had any of the following?

	YES	NO		YES	NO
Acid Reflux/ GERD/ Ulcer (which?) _____			Fibromyalgia/Chronic Fatigue (which?) _____		
Alcohol/Drug ABUSE			Heart Disease (Type?) _____		
Anemia			High Blood Pressure		
Asthma/ Sinus Allergies (which?) _____			Insomnia		
Arthritis			Irritable Bowel Disease		
Autoimmune Disease			Kidney Disease		
Cancer (Type?) _____			Liver Disease/ Hepatitis		
Celiac Disease/ Gluten Sensitivity			Osteoporosis		
Clotting Problem (Type?) _____			Pelvic Pain		
Constipation			Psoriasis/ Eczema/ Rosacea (which?)_____		
Diabetes			Stroke		
Endometriosis			Thyroid Problems		
Epilepsy			Other _____		

FAMILY HISTORY. Please give three generations! Parents/ Grandparents/ Aunts & Uncles Appreciated, Siblings. Adopted? _____

	Who	Age at Dx	Age Now		Who	Age at Dx	Age Now
Autoimmune Disease				High Blood Pressure			
Alzheimers Disease				High Cholesterol			
Alcohol/Depression/Psych Dz				Kidney Problems			
Breast Cancer				Osteoporosis			
Other Cancer Type? _____				Stroke			
Diabetes				Thyroid Problems			
Heart Disease				Other			

-PLEASE GO ON TO SIDE TWO-

HEALTH HABITS

How many hours do you sleep at night? _____ Do you smoke? _____ How many packs per day? _____
Do you eat regular meals including breakfast? _____ Do you use alcohol?_____ Any street drugs? _____
What type of diet do you follow? _____
Do you exercise regularly? _____ If yes, what type of exercise do you do? _____
How often do you exercise? _____ Do you consider yourself healthy? _____
What do you do to relax? _____
Immunizations up to date? _____ Last Mammogram?_____

0B-GYN HISTORY

PREGNANCIES Total _____ Living Children _____ Miscarriages _____ Abortions _____ Tubal Pregnancy _____

BIRTH CONTROL METHOD Pills _____ Nuvaring _____ IUD _____ Depoprovera _____ Condoms _____
Withdrawl _____ Rhythm _____ Tubal Ligation _____ Vasectomy _____ Other _____ None _____

MENSTRUAL HISTORY Age you started your period_____ Age you stopped your period _____ Total flow days _____
Menstrual Interval (first day of flow to first day of next flow) _____

Do you have any of the following:

	YES	NO		YES	NO
Bleeding between periods	_____	_____	**Irregular periods**	_____	_____
Bleeding after intercourse	_____	_____	**Fibroids**	_____	_____
Pain with intercourse	_____	_____	**Heavy Periods**	_____	_____
Pain with periods (cramps)	_____	_____	**PMS**	_____	_____
Infertility	_____	_____	**Vaginal itching**	_____	_____

Date of last Pap Smear: _____ Normal? Yes _____ No _____

Have you ever had: Colposcopy or biopsy of Cervix _____ How many times? _____ Laser _____ Cone _____

Cryosurgery _____ For What Problem? _____ When? _____

Have you ever had a STD? Yes _____ No _____ Type _____ When?_____ Pelvic Inflammatory Disease? Yes ____No ___

Have you ever had herpes? Yes_____ No _____ Have you ever had Venereal Warts? Yes _____ No _____

Do you currently have a sexual relationship? Yes ____ No ____ Is your sex life satisfactory? Yes ____ No _____

Do you have any questions about sex you would like to ask? Yes _____ No _____

Are you happy with your birth control? Yes ____ No ____ Is there a chance you could be pregnant now? Yes ____ No ____

Have you been a victim of abuse? Yes ____ No____ Do you need help? Yes ____ No _____

SYSTEMS REVIEW

Recently have you had the following:

	YES	NO		YES	NO
Severe Headaches	_____	_____	Urinary Incontinence	_____	_____
Acne	_____	_____	Weight Loss or Gain	_____	_____
Chest Pain	_____	_____	Sexual Problems	_____	_____
Breathing Problems	_____	_____	Change in Bowel Habits	_____	_____
Breast Lump	_____	_____	Constipation	_____	_____
Nipple Discharge	_____	_____	Diarrhea	_____	_____
Nausea or Vomiting	_____	_____	Leg Pains or Cramps	_____	_____
Abdominal Pain	_____	_____	Tingling/Numbness in Feet	_____	_____
Pain/Burning on Urination	_____	_____	Painful fingers when cold	_____	_____
Sleep Disturbance	_____	_____	Increased Hair Loss	_____	_____
Unusual Depression	_____	_____	New Skin Problem	_____	_____
Unusual Fatigue	_____	_____	Other problem?	_____	