New Patient Form

DATE: _____ PATIENT NAME: _____

SEX: M_____ F _____ MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED ___

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE SPOKEN: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

STREET ADDRESS: _____ CITY: _____ ZIP CODE: _____

HOME TELEPHONE #: (_____)_____ CELL TELEPHONE #: (_____)_____

EMAIL: _____

EMPLOYED BY: _____ OCCUPATION: _____

WORK #: (_____)_____ BUSINESS ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___)_____

PRIMARY PHARMACY: _____ PHONE #: (___)_____ LOCATION: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

PREVIOUS OBGYN: _____

REASON FOR VISIT: _____

If injury, is it related to: WORK ____ AUTO _____ OTHER ____ DATE OF INCIDENT: _____

PATIENT HISTORY FORM

PATIENT NAME:		DATE OF BIRTH:
Allergies: Medication or item (i.e., latex)	Reaction (Type & severity):	Date of onset:

CURRENT MEDICATIONS (please list ALL medications, including vitamins and supplements):

Name	Dose	Frequency

GYNECOLOGIC HISTORY: please check all that apply

☐ Date of last pap: _____ ☐ Birth Control ☐ Last Mammogram: _____

☐ Abnormal Pap Type: _____ ☐ HPV Vaccine

☐ Menopausal ☐ Last Period: _____

Age at onset: _____ Age at 1st Period: _____

SEXUAL HISTORY: please check all that apply

☐ Sexually Active ☐ STI/STD

☐ Men ☐ Women Type: _____

☐ Sexual Problems Type: _____ How long: _____

☐ Abuse History: _____

OBSTETRIC HISTORY: please include info on ALL pregnancies

Total pregnancies: _____ Full Term: _____ Premature: _____ Abortions: _____

Miscarriages: _____ Ectopic(s): _____ Multiples: _____ Living children: _____

PAST PREGNANCIES: please include ALL info below

Delivery Date	Weeks Pregnant	Gender	Birth Weight	Hours in Labor	Vaginal/ Cesarean	Anesthesia	Complications

FAMILY HISTORY (please check all that apply and indicate which family member/side of family):

☐	Breast Cancer	WHO: _____	Age: _____
☐	Ovarian Cancer	WHO: _____	Age: _____
☐	Colon Cancer	WHO: _____	Age: _____
☐	Endometrial Cancer	WHO: _____	Age: _____
☐	Diabetes	WHO: _____	Age: _____
☐	High Blood Pressure	WHO: _____	Age: _____
☐	Heart Disease	WHO: _____	Age: _____
☐	Stroke	WHO: _____	Age: _____
☐	Thyroid Disease	WHO: _____	Age: _____
☐	Osteoporosis	WHO: _____	Age: _____

SOCIAL HISTORY:

Your Occupation: _____

Marital Status: Single Married Divorced Widowed Partner Name or Spouse (if applicable): _____ DOB: _____

Children's names (if applicable): _____

Current Smoker	If yes, how much: _____	Previous Smoker: ___ Quit: _____
Drink Alcohol	If yes, what type: _____	How often: _____
Drink Caffeine	If yes, what type: _____	How often: _____
Use IV Drugs	If yes, what type: _____	How often: _____
Use Marijuana	If yes, how often: _____	Last used: _____

SURGICAL HISTORY (please list any surgeries you have had):

Procedure	Reason	Year/Date

PAST MEDICAL HISTORY (your personal history) Please check ALL that apply:

- ☐ Abuse
- ☐ Acid Reflux
- ☐ Acne
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ ART (IVF of FET)
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Birth Defect
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Breast Problems
- ☐ Cancer
- ☐ Deep Vein Thrombosis
- ☐ Depression/Postpartum
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Endometriosis
- ☐ G.I. Problems
- ☐ Gestational Diabetes
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hematologic Dysfunction
- ☐ Hepatitis/Liver Disease
- ☐ High Cholesterol
- ☐ History of STI/STD
- ☐ History of Abnormal Pap
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney/Bladder Problems
- ☐ Lung Disease
- ☐ Neurologic/Epilepsy
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ PCOS
- ☐ Polyps
- ☐ Preeclampsia
- ☐ Psychiatric Disorder
- ☐ Pulmonary (TB, etc)
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Trauma
- ☐ Other: _____