Name: _____
Date of Birth: _____

Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please complete all five pages. If you cannot remember specific dates, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where/with whom was your prior gyn care? _____

In the past **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? □ No □ Yes

Feeling down, depressed or hopeless? □ No □ Yes

If you were born between 1945 and 1965 have you been tested for Hepatitis C? ___ yes ___ no

Have you received any or all of the HPV vaccine? ____ yes ____ no

REVIEW OF SYMPTOMS: <u>Circle any of the follow symptoms you have experienced recently:</u>

Fevers	Chills	Weight gain	Weight loss	Fatigue	Changes in vision
Hearing loss	Altered breathing with sleep		Shortness of Breath	Loud Snoring	Wheezing
Chest Pain	Heart palpitations	Blood in Stool	Heartburn	Bloating	Change in BMs
Incontinence of flatus/stool		Constipation	Diarrhea	Abdominal pain	Back pain
Neck pain	Leg swelling	Mood changes	Anxiety	Depression	Sleep problems
Excessive stress	Breast pain	Breast discharge	Skin change on breasts		Breast lump(s)
Changes in /new mole	Itching	Rash	Hair changes	Hair growth on lip/chin/breasts	
Easy bruising	Easy bleeding	Cold intolerance	Heat intolerance	Swollen glands	
Allergies	Recurrent infections	Pain with urination	Loss of urine	Blood in urine	
Frequent urination	Urinary urgency	Vaginal dryness	Pain with sex	Vaginal odor	
Concern about sexual function		Vaginal discharge	Vaginal itch	Hot flashes	
Night sweats	Problems with periods	Vulvar burning	Bleeding with or after sex	PMS	

Abnormal Pap within last 10 years

MEDICATIONS: Please list (or show us your own printed record) all prescription and non-prescription medications, vitamins, home remedies, birth control pill, herbs, inhalers, etc. Use the back of the last page of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATIONS**

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies / Intolerance	Type of Reaction	□ **NO KNOWN ALLERGIES**

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (Cholesterol)	Date	_____	Abnormal?	□ No	□ Yes
Sigmoidoscopy or Colonoscopy (Circle One)	Date	_____	Polyp?	□ No	□ Yes
Eye Exam	Date	_____			
Dental Exam	Date	_____			
Bone Density Test	Date	_____	Abnormal?	□ No	□ Yes
Mammogram	Date	_____	Abnormal?	□ No	□ Yes
Pap Smear	Date	_____	Abnormal?	□ No	□ Yes

OB-GYN HISTORY

Menstrual History

Age of first period: _____
Periods come every _____ days
Period last _____ days
Approximate date of last menstrual period: _____
If not menstruating, age when periods stopped: _____

Pregnancy History

Total number of pregnancies: _____ Number of vaginal births: _____ Number of C-sections: _____
Number of miscarriages: _____ Number of Abortions: _____ Number of Ectopics: _____

Sexual History

Age you first had sex (if applicable): _____
Number of lifetime sexual partners: _____
Sexual partner(s) is/are/have been:
□ None □ Male □ Female □ Both

Sexually involved currently?: □ No □ Yes
Any history of anal sex? □ No □ Yes
(Note: we ask about this as a risk factor for rectal cancer)

Birth control method (circle below all that apply):
No method, Condoms, Pill, Patch, Vaginal Ring, IUD, Tubal Ligation, Diaphragm, Partner has vasectomy, Withdrawal, Natural Family Planning, Depo Shot, Nexplanon,Trying to conceive, None, Abstinence, Hysterectomy/Menopause, Other _____

Would you like to discuss birth control today? □ No □ Yes

Do you wish to be tested for any sexually transmitted diseases today? □ No □ Yes

Medical History
Please place a check next to any medical problem listed below you experience(d).

□	Alcohol/drug abuse	□	Allergies	□	Anxiety
□	Arthritis	□	Asthma	□	Hypothyroidism
□	Hyperthyroidism	□	Blood clot in leg (DVT)	□	Blood clot in lung (PE)
□	Benign breast lump	□	Breast cancer	□	Colon cancer
□	Uterine cancer	□	Ovarian cancer	□	Other cancer _____
□	Cataracts	□	Chicken pox	□	Colon polyp
□	Coronary Artery Disease	□	Depression	□	Diabetes
□	Fracture _____	□	Reflux (GERD)	□	Glaucoma
□	Endometriosis	□	Uterine fibroids	□	Uterine polyp
□	Heart Attack (MI)	□	Hepatitis _____	□	High cholesterol
□	Irritable Bowel (IBS)	□	Kidney Disease/Failure	□	Kidney stones
□	Liver disease	□	Migraine without aura	□	Migraine with aura
□	Osteopenia	□	Osteoporosis	□	Seizures/Epilepsy
□	Sexually Transmitted Disease	□	Eczema	□	Sleep Apnea
□	Stomach Ulcer	□	Stroke/TIA	□	High blood pressure/hypertension

□ Other:
_____

_____

Misc. Info

Occupation (or prior occupation): _____retired / unemployed / leave of absence / disabled (circle one)
Employer: _____ Years of education or highest degree: _____
Marital Status (circle one): Single / Partner / Married / Divorced / Widowed
Spouse / Partner's name: _____ Number of children: _____ Ages if under 18 years: _____
Number of grandchildren: _____ Number of great grandchildren: _____
Who lives at home with you? _____
Leisure activities, group involvement, religion, volunteer work, recent travel:

_____

_____

Surgical History: Please check off any procedure or surgeries and dates (if known).

□ **NONE**

Surgical Procedure	***Check if Yes***	***Year***	***Comments***
Abdominal Surgery (Major)			
Appendectomy (Appendix Removal)			
Back Surgery (Lumbar)			
Biopsy (location)			
Breast Biopsy			Circle: Right Left Both
Mastectomy			Circle: Right Left Both
Breast Lumpectomy			Circle: Right Left Both
Breast Reduction			
Breast Augmentation			
Coronary Bypass			
Coronary Stent			
Dilation & Curettage (D&C)			
EGD (Stomach Endoscopy)			
Endometrial Ablation			
Cataract			Circle: Right Left Both
Cholecystectomy (Gallbladder Removal)			Circle: Laparoscopic
Heart Surgery (other than Coronary Bypass)			
Hernia Removal			Circle: Abdominal Inguinal
Hip Surgery			Circle: Right Left Both
Hysterectomy (total, including ovaries)			Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Right Left Both
LEEP/cone biopsy/cryosurgery (Cervix Surgery)			
Neck Surgery			
Ovary Removal			Circle: Right Left Both
Sigmoidoscopy / Colonoscopy			
Tonsillectomy			
Adenoidectomy			
Tubal Ligation			
Abdominoplasty			
Gastric Bypass			
Other (List)			

Tobacco Use
Smoke Cigarettes: □ Never □ No □ Yes
How many years have/had you smoked? _____
Packs/day: _____
Quit date (if applicable): _____
Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use
Do you drink alcohol? □ No □ Yes
# of drinks/week: _____ □ Beer □ Wine □ Liquor

Drug Use
Do you use marijuana or other recreational drugs? □ No □ Yes
Ever use needles to inject non-prescribed drugs? □ No □ Yes

Sleep
Average number of hours of sleep each night: _____

Exercise: Do you exercise regularly? □ No □ Yes
What kind of exercise? _____
How long (minutes)? _____ How often? _____

Safety
Do you use seatbelts consistently? □ No □ Yes
Is violence at home a concern for you? □ No □ Yes
Have you ever been forced to have sex? □ No □ Yes
Any history of sexual abuse? □ No □ Yes
Any history of physical /psychological abuse? □ No □ Yes

Family History

Adopted - Yes No (Please Circle) If yes and you do **NOT** know your family history skip this section

FAMILY HISTORY - Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
D - Deceased A - Alive										
No significant history known										
Alcoholism/Drug Abuse										
Alzheimer's / Dementia										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Ovarian										
Cancer Uterine										
Cancer Other Type										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression/Suicide/Anxiety										
Diabetes (adult onset)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (Other)										
High Blood Pressure – Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism/Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Stroke										
Thyroid Disease										
Other (list)										