Wendy Giles, MD

New Patient Forms

List All Operations You Ever Had Minor and Major.

Year	Name of Procedure

Family History:
Have your grandparents, parents, brothers, sisters, uncles, aunts or children even been treated for: (please specify who)

Heart Trouble: _____ High Blood Pressure: _____
Diabetes: _____ Leukemia: _____
Tuberculosis: _____ Muscular Disorders: _____
Cancer: _____

Menstrual History:
First day of last period: _____
Up to this time periods have been: _ Regular _ Somewhat irregular _ Completely irregular
Are you sexually active? _____ Have you ever been sexually active? _____
Do you ever have any bleeding or spotting following sexual intercourse? _____
Have you ever had an abnormal Pap Smear? _____ If yes, what kind of treatment performed? _____
When was your last Pap Smear? _____ Where? _____
Was Pap Smear normal? _____

Marital History:
_ Single _ Married _ Separated _Widowed _ Partnered _ Divorced Number of years married? _____
Married more than once? _____ How many times? _____
Do you use contraceptive? _____
Please circle which method:
Diaphragm Condom Sponge Foam Withdrawal Birth Control Pills Rhythm IUD Tubal Ligation
Vasectomy Abstinence Other: _____
_ Used always without fail _ Used most of the time _ Used some of the time

Personal Habits: Smoking? _____ Alcohol? _____ Drugs? _____
Do you get Influenza Vaccine? _ YES _ NO If so date of last shot: _____

Prescribed Medications presently taking: (please specify dosage and directions)

_____ _____
_____ _____
_____ _____

Non-Prescribed medications or supplements presently taking:

_____
_____
_____
_____

Drug Allergies:

_____