Mills
Obstetrics & Gynecology

NEW PATIENT FORM

PATIENT HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____

SS#: _____

ADDRESS:

_____

_

CITY: _____ STATE: _____

ZIP CODE_____

PREFERRED PHONE #: _____

ALT. PHONE #:_____

EMAIL:

_____

EMPLOYER:

_____

MARITAL STATUS: SINGLE MARRIED LONG-TERM RELATIONSHIP DIVORCED
WIDOWED

CURRENT INSURANCE: _____

ID#: _____GROUP#:_____

POLICY HOLDER NAME: _____

DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT US/REFERRING PHYSICIAN?

_____

REASON FOR VISIT:

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME & ADDRESS: _____

HAVE YOU HAD ROUTINE LABS (CBC, CHOLESTEROL, THYROID, GLUCOSE, HA1C) CHECKED THIS YEAR? NO YES

CURRENT MEDICATIONS (PLEASE LIST ALL MEDICATIONS, VITAMINS, AND SUPPLEMENTS)

_____

_____

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

IF YES, LIST MEDICATION AND REACTION:

_____

_____

_____

_____

VACCINE HISTORY

TDAP NO YES IF YES, DATE OF VACCINATION _____

PNEUMONIA NO YES IF YES, DATE OF VACCINATION _____

GARDASIL (HPV) NO YES IF YES, DATE OF VACCINATION _____

SHINGLES NO YES IF YES, DATE OF VACCINATION _____

FLU NO YES IF YES, DATE OF VACCINATION _____

GYNECOLOGICAL HISTORY

AGE OF FIRST PERIOD: _____

ARE YOU STILL HAVING PERIODS? YES NO

IF YES, WHEN WAS THE FIRST DAY OF YOUR LAST PERIOD? _____,

DO YOU HAVE CRAMPS DURING YOUR PERIODS? YES NO

IF STILL HAVING PERIODS, IS YOUR PERIOD FLOW: LIGHT MODERATE HEAVY

IF STILL HAVING PERIODS, HOW LONG DO YOUR PERIODS LAST? _____

PATIENT NAME:_____DATE OF BIRTH:_____

ARE YOU SEXUALLY ACTIVE? YES NO

IF YOU ARE NO LONGER HAVING PERIODS, WHAT IS THE REASON (CIRCLE REASON)? NATURAL MENOPAUSE HYSTERECTOMY

ENDOMETRIAL ABLATION OTHER_____

IF YOU HAD A HYSTERECTOMY, WERE YOUR OVARIES REMOVED? YES NO

CIRCLE CURRENT BIRTH CONTROL METHOD:

CONDOMS BIRTH CONTROL PILLS DIAPHRAGM FEMALE CONDOMS PROGESTERONE IUD TUBAL LIGATION

COPPER IUD NEXPLANON MONTHLY VAGINAL RING YEARLY VAGINAL RING VASECTOMY

WITHDRAW METHOD (NATURAL FAMILY PLANNING HYSTERECTOMY MENOPAUSE

DO YOU HAVE PROTECTED SEX? ALWAYS USUALLY NO

PAP SMEAR/ MAMMOGRAM/ BONE DENSITY/ COLONOSCOPY HISTORY

DATE OF LAST PAP: _____ HAVE YOU HAD TREATMENT FOR ABNORMAL PAP SMEARS? NO YES

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR ABNORMAL PAP SMEARS LISTED BELOW:

CRYOTHERAPY NO YES IF YES, WHEN? _____ LASER OF CERVIX NO YES IF YES, WHEN? _____

CONE BIOPSY NO YES IF YES, WHEN? _____ LOOP EXCISION NO YES IF YES, WHEN? _____

DATE OF LAST MAMMOGRAM, IF YOU HAVE HAD ONE_____ WAS IT NORMAL? YES NO

HAVE YOU HAD A BONE DENSITY TEST? NO YES IF YES, DATE: _____ RESULT_____

HAVE YOU HAD A COLONOSCOPY? NO YES IF YES, DATE: _____ RESULT: _____

PATIENT NAME:_____DATE OF BIRTH:_____

PREGNANCY HISTORY

HAVE NEVER BEEN PREGNANT YES NO

OF PREGNANCIES _____ # OF FULL-TERM BIRTHS _____ # OF PRETERM BIRTHS (<37 WEEKS GESTATION) _____

OF PREGNANCY LOSSES (SPONTANEOUS MISCARRIAGES OR INDUCED ABORTIONS) _____ # ECTOPIC PREGNANCIES____

OF LIVING CHILDREN _____

IF MISCARRIAGE OR INDUCED ABORTION, DID YOU HAVE TO HAVE SURGICAL TREATMENT SUCH AS D&C? YES NO

DATE	PLACE OF DELIVERY	DURATION OF PREGNANCY (WEEKS)	HOURS OF LABOR	TYPE OF DELIVERY (VAGINAL VS C-SECTION)	COMPLICATIONS WITH MOTHER/ INFANT	CHILD'S SEX	BIRTH WEIGHT	PRESENT HEALTH

FAMILY HISTORY

ILLNESS	RELATION
AIDS (HIV)	_____
RHEUMATOID ARTHRITIS	_____
DIABETES	_____
DVT	_____
ENDOMETRIAL CANCER	_____
STROKE	_____
HEART DISEASE	_____
UTERINE CANCER	_____
HIGH BLOOD PRESSURE	_____
THYROID DISEASE	_____

PATIENT NAME:_____DATE OF BIRTH:_____

HIGH CHOLESTEROL _____

ANEMIA/ BLOOD DISORDER _____

KIDNEY DISEASE _____

ANESTHESIA COMPLICATIONS _____

LUNG CANCER _____

AUTOIMMUNE DISORDERS (LUPUS, RHEUMATOID, RENAUD'S) _____

BIRTH DEFECTS _____ _

OSTEOPOROSIS _____

BREAST CANCER _____

OVARIAN CANCER _____

COLON CANCER _____

OTHER _____

SOCIAL HISTORY

DO YOU SMOKE? NO YES _____ PACKS/DAY FORMER SMOKER? NO YES _____ PACKS/DAY _____ YEARS

DO YOU VAPE? NO YES HOW OFTEN? _____

ARE YOU EXPOSED TO SECONDHAND SMOKE? NO YES

ARE THERE CO2/ SMOKE DETECTORS IN YOUR HOME? NO YES

DO YOU: LIVE ALONE WITH OTHERS

DO YOU WEAR SEATBELTS ROUTINELY? NO YES

DO YOU ROUTINELY USE SUNSCREEN? NO YES

IS A BLOOD TRANSFUSION ACCEPTABLE IN AN EMERGENCY? NO YES

DO YOU HAVE AN ADVANCED DIRECTIVE? NO YES

DO YOU HAVE ANY OCCUPATIONAL HEALTH RISKS? NO YES

EDUCATION LEVEL _____

STRESS LEVEL: LOW MEDIUM HIGH

DIET: REGULAR VEGETARIAN OTHER: _____

EXERCISE: TYPE_____ HOW OFTEN? _____

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL

HAS THERE BEEN A NEW SEXUAL PARTNER IN THE LAST YEAR? NO YES

IS SEXUAL INTERCOURSE PAINFUL? NO YES

DO YOU DRINK ALCOHOL? NO YES IF YES, HOW MANY DRINKS PER WEEK? _____

CAFFEINE INTAKE: NONE OCCASIONAL MODERATE HEAVY

DO YOU USE ILLICIT DRUGS? NO YES IF YES, WHAT TYPE? _____ LAST USED_____

NUMBER OF HOURS OF SLEEP EACH NIGHT: _____

PATIENT NAME:_____DATE OF BIRTH:_____

PAST OBSTETRICAL/ GYNECOLOGICAL SURGERIES CHECK ANY THAT APPLY OR: _____ NONE

SURGERY	YEAR	SURGERY	YEAR
D&C	_____	LEFT OVARIAN CYST REMOVED	_____
HYSTEROSCOPY	_____	RIGHT OVARIAN CYST REMOVED	_____
INFERTILITY SURGERY	_____	LEFT OVARY REMOVED	_____
LAPAROSCOPY	_____	RIGHT OVARY REMOVED	_____
CESAREAN SECTION	_____	MYOMECTOMY	_____
		VAGINAL OR BLADDER REPAIR	_____

OTHER

_____

PATIENT NAME: _____DATE OF BIRTH: _____

PAST SURGICAL HISTORY (NOT OB/GYN) AND YEAR _____ NONE

_____

_____

_____

_____

PERSONAL MEDICAL HISTORY _____ NONE

AIDS (HIV) HERPES (HSV) ANEMIA/ BLOOD DISORDER HIGH BLOOD PRESSURE

ANESTHESIA COMPLICATIONS HIGH CHOLESTEROL ANXIETY DISORDER
INFERTILITY

ARTHRITIS LUPUS KIDNEY OR BLADDER PROBLEM LIVER DISEASE

BIRTH DEFECTS OR INHERITED DISEASE LUNG DISEASE: TYPE _____

BLOOD TRANSFUSION OVARIAN CANCER BREAST CANCER DEPRESSION

BIPOLAR DISORDER SCHIZOPHRENIA OTHER PSYCHIATRIC DISORDER_____

BREAST PROBLEM: TYPE _____ RHEUMATIC FEVER

CANCER: TYPE _____ DVT PULMONARY EMBOLISM

SEASONAL ALLERGIES CHLAMYDIA/GONORRHEA SEXUAL ABUSE/ DOMESTIC VIOLENCE

STOMACH, BOWEL, OR GALLBLADDER PROBLEMS

DIABETES: TYPE _____ SYPHILIS THYROID PROBLEMS

ENDOMETRIOSIS (DIAGNOSED SURGICALLY) PCOS FEMALE/SEXUAL PROBLEMS HEADACHES/ MIGRAINES

VARICOSITIES (VARICOSE VEINS) HEART CONDITIONS

HEPATITIS: TYPE _____

OTHER: _____

PATIENT SIGNATURE: _____ **DATE:**

_____