Mills
Obstetrics & Gynecology

NEW GYN PATIENT FORM

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: _____

POLICY HOLDER'S DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT US/REFERRING PHYSICIAN: _____

REASON FOR VISIT:

_____

NAME:_____DOB:_____

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):

_____

_____

_____

ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATION? _____YES _____NO

IF YES, LIST MEDICATION AND REACTION:_____

PATIENT NAME_____DOB_____

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? _____

NAME:_____DOB:_____

ARE YOU SEXUALLY ACTIVE? _____YES _____NO

IF YOU ARE NO LONGER HAVING PERIODS, WHAT IS THE REASON? _____NATURAL MENOPAUSE

_____HYSTERECTOMY _____ENDOMETRIAL ABLATION OTHER_____

IF YOU HAD A HYSTERECTOMY, WERE YOUR OVARIES REMOVED? ____YES ____NO

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 ____NEVER

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 SUCH AS:

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: _____

NAME:_____DOB:_____

PREGNANCY HISTORY:

HAVE YOU EVER BEEN PREGNANT? _____YES _____NO

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

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

PREGNANCY DETAILS

(LIST **ALL** PREGNANCIES, INCLUDING MISCARRIAGES, TERMINATIONS, ECTOPIC PREGNANCIES,ETC)

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

NAME:_____DOB:_____

FAMILY MEDICAL HISTORY:

ILLNESS	RELATION (MOTHER, FATHER, SISTER, MATERNAL/PATERNAL GRANDMOTHER/GRANDFATHER, AUNT)
AIDS (HIV)	_____
RHEUMATOID ARTHRITIS	_____
DIABETES	_____
DVT	_____
ENDOMETRIAL CANCER	_____
STROKE	_____
HEART DISEASE	_____
UTERINE CANCER	_____
HIGH BLOOD PRESSURE	_____
THYROID DISEASE	_____
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	_____

NAME:_____DOB:_____

SOCIAL HISTORY:

DO YOU SMOKE? _____NO _____YES IF YES, PACKS/DAY_____

FORMER SMOKER? _____NO _____YES _____ PACKS/DAY _____ YEARS

DO YOU VAPE? _____ NO _____YES IF 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 COMPLETED _____

STRESS LEVEL: _____LOW _____MEDIUM _____HIGH

DIET: _____REGULAR _____VEGETARIAN OTHER: _____

EXERCISE: _____NO _____YES IF YES, 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: _____

DO YOU PERFORM MONTHLY SELF BREAST EXAMS? _____ NO _____YES

NAME:_____DOB:_____

PAST OBSTETRICAL/ GYNECOLOGICAL SURGERIES:

CHECK ANY THAT APPLY OR: _____ NONE

SURGERY	YEAR
D&C	_____
OVARIAN CYST REMOVED ____LEFT ____RIGHT	_____
HYSTEROSCOPY	_____
INFERTILITY SURGERY	_____
OVARY REMOVED _____LEFT _____RIGHT	_____
TUBAL LIGATION	_____
LAPAROSCOPY	_____
CESAREAN SECTION	_____
MYOMECTOMY	_____
VAGINAL OR BLADDER REPAIR	_____
ECTOPIC PREGNANCY SURGERY	_____
HYSTERECTOMY ____LAPAROSCOPIC _____VAGINAL _____ABDOMINAL	_____

OTHER GYN SURGERIES: _____

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

_____

_____

PERSONAL MEDICAL HISTORY: _____ NONE

_____AIDS (HIV)

_____ANEMIA/ BLOOD DISORDER

_____ANESTHESIA COMPLICATIONS

_____ARTHRITIS

_____ANXIETY DISORDER

_____INFERTILITY

_____BIRTH DEFECTS OR INHERITED DISEASE

_____BLOOD TRANSFUSION

_____BREAST CANCER

____HERPES (HSV)

____HIGH BLOOD PRESSURE

____HIGH CHOLESTEROL

____HEPATITIS B

____HEPATITIS C

____LUPUS

____KIDNEY OR BLADDER PROBLEM

____LUNG DISEASE: TYPE

____OVARIAN CANCER

NAME:_____DOB:_____

PERSONAL MEDICAL HISTORY (CONT):

_____BIPOLAR DISORDER

_____BREAST PROBLEM: TYPE _____

_____DVT

_____BREAST PROBLEM: TYPE _____

_____PULMONARY EMBOLISM

_____CHLAMYDIA/GONORRHEA

_____STOMACH, BOWEL, OR GALLBLADDER PROBLEMS

_____DIABETES: TYPE _____

_____ENDOMETRIOSIS (DIAGNOSED SURGICALLY)

_____FEMALE/SEXUAL PROBLEMS

_____VARICOSITIES (VARICOSE VEINS)

____SCHIZOPHRENIA

____RHEUMATIC FEVER

____OTHER PSYCHIATRIC DISORDERS

____CANCER: TYPE _____

____SEASONAL ALLERGIES

____SEXUAL ABUSE/ DOMESTIC VIOLENCE

____SYPHILIS

____THYROID PROBLEMS

____PCOS

____HEADACHES/ MIGRAINES

____HEART CONDITIONS

_____OTHER MEDICAL PROBLEMS: _____

PATIENT NAME:_____DOB:_____

REVIEW OF SYSTEMS

PLEASE CHECK MARK ANY PROBLEMS YOU ARE HAVING: OR _____NO COMPLAINTS AT THIS TIME

CONSTITUTIONAL: _____NO COMPLAINTS

_____FEVER

_____FATIGUE

_____ SIGNIFICANT WEIGHT LOSS-_____ LBS

_____ SIGNIFICANT WEIGHT GAIN-_____ LBS

ADDITIONAL INFO_____

CARDIOVASCULAR: _____ NO COMPLAINTS

_____CHEST PAIN

_____IRREGULAR HEARTBEAT

_____DIFFICULTY BREATHING

ADDITIONAL INFO_____

GASTROINTESTINAL: _____ NO COMPLAINTS

_____HEARTBURN _____DIFFICULTY SWALLOWING

_____NAUSEA _____VOMITING

_____ABDOMINAL PAIN _____BOWEL MOVEMENT CHANGES

_____DIARRHEA _____CONSTIPATION

_____RECTAL BLEEDING

ADDITIONAL INFO_____

NAME:_____DOB:_____

GENITOURINARY: _____ NO COMPLAINTS

_____BLOOD IN URINE _____ABNORMAL VAGINAL BLEEDING

_____FLANK PAIN _____TROUBLE URINATING

_____URINARY FREQUENCY _____URINARY URGENCY

_____PAINFUL URINATION _____FREQUENT URINATION AT NIGHT

_____INCONTINENCE _____RASH

_____LESION _____DISCHARGE

_____VAGINAL ODOR _____VAGINAL ITCHING

ADDITIONAL INFO_____

ENDOCRINE: _____NO COMPLAINTS

_____THYROID DISEASE

_____TYPE 2 DIABETES

ADDITIONAL INFO_____

MENSTRUAL: _____NO COMPLAINTS

_____CURRENTLY NO PERIOD DUE TO:_____

_____IRREGULAR TIMING _____LIGHT FLOW ____BLOATING

_____HEAVY FLOW _____SEVERE CRAMPING ____DEPRESSION

_____MOOD SWINGS _____IRRITABILITY

_____TENSION/ANXIETY _____BREAST PAIN/TENDERNESS

_____FEELING OUT OF CONTROL/OVERWHELMED

ADDITIONAL INFO_____

MENOPAUSAL: _____NO COMPLAINTS

_____HOT FLASHES _____NIGHT SWEATS _____DIFFICULTY CONCENTRATING

_____VAGINAL DRYNESS _____MEMORY LOSS

ADDITIONAL INFO_____

NAME:_____DOB:_____

SEXUAL: _____NO COMPLAINTS

_____DECREASED SEX DRIVE _____PAINFUL INTERCOURSE

_____VAGINAL TIGHTNESS _____VAGINAL DISCOMFORT

_____BLEEDING WITH INTERCOURSE

ADDITIONAL INFO_____

PSYCH: _____NO COMPLAINTS

_____DEPRESSION _____ANXIETY

_____ALCOHOLISM _____SLEEP DISTURBANCES

ADDTIONAl INFO_____

BREAST: _____NO COMPLAINTS

_____BREAST LUMP _____BREAST MASS

_____NIPPLE DISCHARGE _____SKIN CHANGES

_____BREAST PAIN: _____LEFT _____RIGHT

ADDITIONAL INFO_____

PAIN: ____NO COMPLAINTS

____CHRONINC PAIN: _____NECK _____BACK ____JOINT

ADDITIONAL INFO_____

PATIENT NAME:_____ DOB:_____

FEMALE SYMPTOM CHECKLIST

SYMPTOMS (PLEASE CHECK MARK)	NEVER	MILD	MODERATE	SEVERE
FATIGUE				
MEMORY LOSS				
MENTAL CONFUSION				
DECREASED SEX DRIVE OR LIBIDO				
SLEEP PROBLEMS				
MOOD CHANGES/ IRRITABILITY				
TENSION				
MIGRAINES/ SEVERE HEADACHES				
DIFFICULTY TO CLIMAX SEXUALLY				
BLOATING				
WEIGHT GAIN				
BREAST TENDERNESS				
VAGINAL DRYNESS				
HOT FLASHES				
NIGHT SWEATS				
DRY OR WRINKLED SKIN				
HAIR FALLING OUT				
COLD ALL THE TIME				
SWELLING ALL OVER				
JOINT PAIN				

NAME:_____DOB_____

HISTORY OF BREAST CANCER: SELF (Y/N):_____ FAMILY MEMBER:_____

HAVE YOU EVER HAD ANY ISSUES WITH ANESTHESIA (Y/N):_____EXPLAIN:_____

CURRENT HORMONE REPLACEMENT THERAPY:_____

PAST HORMONE REPLACEMENT THERAPY:_____

NUTRITIONAL SUPPLEMENTS OR VITAMINS: _____

LAST MENSTRUAL PERIOD (ESTIMATE YEAR IF KNOWN):_____

BIRTH CONTROL METHOD:_____

DATE OF LAST MAMMOGRAM:_____

DATE OF LAST PAP SMEAR:_____

I WANT TO BE SEXUALLY ACTIVE (Y/N): _____

I HAVE COMPLETED MY FAMILY (Y/N): _____

HISTORY OF HEART DISEASE (Y/N):_____

HISTORY OF DIABETES (Y/N): _____

HISTORY OF OSTEOPOROSIS (Y/N):_____

HISTORY OF ALZHEIMER'S DISEASE (Y/N):_____