WELCOME TO OUR PRACTICE

(NEW PATIENT FORM)

Personal Profile

Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Occupation: _____

Marital Status: _____

School Completed: ☐ Yes or ☐ No

Graduate Degree ☐College ☐High School ☐Other

Primary Care Physician:

_____

Who may we thank for referring you to our practice: _____

Are You Here Today For:

☐ Routine Annual Exam
☐ Sick Office Visit:
☐ Consult

If Your Visit Is For A Problem, Please Describe _____

Gynecologic History

1). Are you currently pregnant? Yes or No Current Birth Control: Yes or No. Last Menstrual period (First Day): _____ Age periods began: _____ Number of days bleeding: _____Number of days between periods: _____ Any recent changes in periods? Yes or No Any pain during cycle: Yes or No

2). Last Pap Smear: Abnormal Pap in the past? Yes or No.

3). Abnormal mammograms in the past? Yes or No

Last Colonoscopy: _____Last Bone Density scan:_____Last Mammogram_____Are you currently sexually active: Yes or No Menopause: Yes or No

History of infertility: Yes or No

Bleeding during intercourse: Yes or No Pain during intercourse: Yes or No Vaginal Discharge: o Yes or o No History of Sexually transmitted Disease: ☐Yes or ☐No

If Yes (Circle all that apply): Herpes, Gonorrhea, Chlamydia, Genital Warts Trichomonas, HIV, Syphillis,

Total Number of Partners:_____ Sexual preference: Male, Female, other Do you desire STD testing?

☐Yes ☐ No

Obstetric History

Total number of pregnancies:_____

Pregnancy type:_____

How many full term:_____

Premature(<37wks):_____ Still Born:_____ Tubal Pregnancies:_____

Miscarriages:_____ Abortions:_____

Living Children:_____

Any Complication during pregnancy: ☐Yes ☐No

Were you considered High risk patient: Yes or No If Yes, explain why:_____

_____

Please list each pregnancy below (Pregnacy History)

	Date of birth	Weight	Sex	Weeks pregnant	Complications	Type of delivery (vag/ c-section)
1).						
2).						
3).						
4).						
5).						
6).						

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Use of Tobacco:
Never____ Previously, (But Quit)____ Current # packs per day____
Use of Street Drugs: Marijuana: ____ Cocaine: ____ Crystal Meth: ____
Other_____

Seat belt use ☐ Yes ☐ No
Have you ever been sexually abused, threatened or hurt by anyone? ☐ Yes ☐ No
Domestic Violence ☐ Yes ☐ No
Regular Exercise ☐ Yes ☐ No

Do you currently drink alcohol? ☐ Yes ☐ No If yes, How much?
_____

Operations/ Hospitalizations (Include approximate dates)
Hospital Complication

1._____
2._____
3._____
4._____
5._____
6._____

Medications (Include over-couner)
Drug Name/Dose
1). _____ 2). _____
3). _____ 4). _____
5). _____ 6). _____

Medication Allergies:
1). _____ 2). _____
3). _____ 4). _____
5). _____ 6). _____

Social History
Use of Alcohol:
Rarely____ Never____
Daily____ Moderate____

Personal Medical History
1). _____ 2). _____
3). _____ 4). _____
5). _____ 6). _____

Cardiovascular:
- ☐ Arrhythmia
- ☐ Blood Clot in Leg or Lungs

Where:_____
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Stent

Respirtory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Shortness of breath
- ☐ Tubercolosis
- ☐ Pneumonia

☐ Gastrointestinal:
- ☐ Vomiting
- ☐ Acid Reflux
- ☐ Crohns Disease
- ☐ Ulcer
- ☐ Unexplained Weight Loss Or Gain
- ☐ Constipation
- ☐ Bowel Problems

Hepatic/Liver Disease:
- ☐ Cirrhosis
- ☐ Hepatitis A B C
- ☐ Pancreatitis

Infectious Disease:
- ☐ HIV
- ☐ MRSA
- ☐ Tuberculosis
- ☐ Rheumatic
- ☐ Kidney Stones
- ☐ Urinary Tract Infection

Neurologic:
- ☐ ADHD
- ☐ Alzheimer's
- ☐ Diabetic
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Polio
- ☐ Seizure/Convulsion/Epilepsy
- ☐ Stroke
- ☐ TIA
- ☐ Migraine Or Headaches
- ☐ Numbness

Endocrine:
- ☐ Adrenal abnormality
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Thyroid Disease
- ☐ Abnormal Hair Growth Or Loss

Musculoskeletal:
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Ankylosing Spondylitis
- ☐ Arthritis/Joint Pain
- ☐ Fracture

Psychiatric:
- ☐ Acute stress disorder
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Panic disorder
- ☐ Schizophrenia

Cancer: List:_____
_____
_____

Gyn:
- ☐ Abnormal painful/heavy periods
- ☐ History of blood transfusion

Would you accept a blood transfusion?
- ☐ Yes ☐ No
- ☐ Infertility
- ☐ Herpes
- ☐ Lumps or breasts pain
- ☐ Nipple discharge
- ☐ Uterine fibroids

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Gyn (cont.)

- ☐ Vaginal discharge
- ☐ Rash
- ☐ Involuntary loss of urine

Family History Non Contributory

Mother
- ☐ Living
- ☐ Decease/Cause of death _____

Father
- ☐ Living
- ☐ Decease/Cause of death _____

Siblings
- ☐ Living
- ☐ Decease/Cause of death _____

Children
- ☐ Living
- ☐ Decease/Cause of death _____

Maternal Grandmother
- ☐ Living
- ☐ Decease/Cause of death _____

Maternal Grandfather
- ☐ Living
- ☐ Decease/Cause of death _____

Paternal Grandmother
- ☐ Living
- ☐ Decease/Cause of death _____

Paternal Grandfather
- ☐ Living
- ☐ Decease/Cause of death _____

Illness

Age of onset _____
Which Realtives _____
Birth Defects _____
Blood Clots In Legs/Lungs _____
Breast Cancer _____ Colon Cancer _____ Ovarian Cancer _____ Uterine Cancer _____
Any Other Cancer _____ Cystic Fibrosis _____ Downs Syndrome _____
Heart Disease _____
High Blood Pressure _____
Cholesterol _____
Sickle Cell Disease _____
Stroke _____

Please check any symptoms, which you are currently experiencing: _____
_____

Review of system

Constitutional:
- ☐ Negative
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever

Head, Ears, Nose, Throat/Eyes:
- ☐ Negative
- ☐ Headache
- ☐ Sore throat
- ☐ Decreased hearing
- ☐ Vision change
- ☐ Glasses/contacts
- ☐ Tinnitus
- ☐ Ulcers
- ☐ Sinusitis
- ☐ Other

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Breast:
- ☐ Negative
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Mastalgia (painful breast)
- ☐ Nipple discharge

Cardiovascular:
- ☐ Negative
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Palpitation
- ☐ Orthopnea
- ☐ DOE
- ☐ Edema
- ☐ Other_____

Respiratory:
- ☐ Negative
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Hematopsis

Genitourinary
- ☐ Negative
- ☐ Bloody urine
- ☐ Incontinent
- ☐ Urgency
- ☐ Frequency
- ☐ Incomplete emptying
- ☐ Abnormal bleeding
- ☐ Pain with intercourse
- ☐ Dysuria
- ☐ Dyspareunia

Musculoskeleta/Neurologicall
- ☐ Negative
- ☐ Dizziness
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Trouble Walking

Skin
- ☐ Negative
- ☐ Discharge
- ☐ Masses
- ☐ Rash
- ☐ Ulcer
- ☐ Other_____

Psychiatric
- ☐ Negative
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Other_____

Hematology/Lymph
- ☐ Negative
- ☐ Easy bruising
- ☐ Bleeding problems
- ☐ Adenopathy (Swollen lymph nodes)
- ☐ Other_____

Describe:_____

GI / Digestive
- ☐ **Negative**
- ☐ Diarrhea
- ☐ Constipation
- ☐ Flatulence
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Nausea/Vomiting
- ☐ Other

Endocrine
- ☐ Negative
- ☐ Hypothyroidism
- ☐ Hypethyroidism
- ☐ Hot Flashes
- ☐ Diabetes

THANK YOU!

Most insurance carriers will cover your Annual Well Woman Exam once per calendar year. Your Well Woman Exams consists of a breast exam, pelvic exam and pap smear. If you're experiencing any issues, and wish to be evaluated, then you are not considered a "well woman" and your visit is no longer considered preventative. Additional services may be billed for any additional issues discussed resulting in patient responsibility, dependent upon your individual benefi ts.

Signature: _____

Date: _____

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