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NEW PATIENT MEDICAL HISTORY

Legal name: ____ **Date:** __________________________

How would you like to be addressed? ☐ First name ☐ Last name ☐ Nickname ______________________

Date of Birth: ______________ **Age:** _______ **Height** _______ **Weight:** _______ **Marital Status:** _______________

Who referred you to our practice: __________________ **Name of your primary care physician:** __________________________

HISTORY OF PRESENT ILLNESS

Describe reason(s) for your visit: ____

____

____

Menstrual History:

- Do you have regular menstrual periods? ☐N ☐Y
- Date of last menstrual period: __________
- Has there been any change in your periods? ☐N ☐Y
- Do you have episodes of pelvic pain? ☐N ☐Y Severity (scale 1-10): ____
- Do you have pain with our periods? ☐N ☐Y Severity (scale 1-10): ____
- Do you experience menopausal symptoms (hot flashes, night sweats)? ☐N ☐Y How often? _____________

Pelvic symptoms: Do you have any of the following?

- Pelvic pressure, low back pain, sensation of your organs falling out? ☐N ☐Y
- PMS (i.e. irritability, weight gain, breast tenderness, bloating, depression)? ☐N ☐Y
- Questions regarding your sexual response? ☐N ☐Y
- Number of lifetime sexual partners? __________

Current method of contraception (including vasectomy)**:** ____

Date of last Pap Smear: __________________ **History of abnormal Pap?** ☐N ☐Y When? _________________

REVIEW OF SYMPTOMS

Do you currently have any of the following symptoms? If yes, please describe:

1. **General:** headaches, unexplained weight loss? ☐N ☐Y ____
2. **Eyes:** contact lens, double vision, glaucoma? ☐N ☐Y ____
3. **Ears, Nose, or Throat:** sinus, difficulty swallowing ☐N ☐Y ____
4. **Cardiovascular:** chest discomfort, unusual heartbeat, mitral valve prolapse, high blood pressure, leg swelling, shortness of breath? ☐N ☐Y ____
5. **Respiration:** shortness of breath, chronic cough? ☐N ☐Y ____
6. **Integumentary:** **Breasts:** cysts, nodules, pain ☐N ☐Y ____
   Skin: acne, skin cancer ☐N ☐Y ____
7. **Gastro-Intestinal:** abdominal pain, bloating, diarrhea, constipation, rectal bleeding? ☐N ☐Y ____
8. **Endocrine:** excessive thirst, fatigue, too hot/cold? ☐N ☐Y ____
9. **Hematologic/Lymphatic:** swollen glands, anemia? ☐N ☐Y ____
10. **Musculo-Skeletal:** neck, back or joint pain? ☐N ☐Y ____
11. **Neurologic:** numbness, seizures, stroke or TIA? ☐N ☐Y ____
12. **Psychiatric:** anxiety, depression, mood swings? ☐N ☐Y ____

13. Urinary:

- Recurrent kidney or bladder infections? ☐N ☐Y
- Loss of urine when coughing, sneezing, or exercising? ☐N ☐Y
- Wear a pad for "just in case" protection"? ☐N ☐Y
- Regularly get up at night to urinate? ☐N ☐Y How often? _______
- Avoid physical activities due to poor bladder control? ☐N ☐Y
- Unable to go for more than 3 hours without urination? ☐N ☐Y How often (hours)? _______

PERSONAL, FAMILY AND SOCIAL HISTORY

Personal History:

Obstetrical History:

# of pregnancies: ______ # of vaginal deliveries: ______ # of cesarean sections: ______

# of miscarriages: ______ # of elective abortions: ______ Do you plan more pregnancies? ☐N ☐Y

Illnesses or Diseases: (Please list)

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Major Operations: (Please list) Date: Reason for surgery:

___________________________________ __________ ___________________________________

___________________________________ __________ ___________________________________

___________________________________ __________ ___________________________________

___________________________________ __________ ___________________________________

___________________________________ __________ ___________________________________

Family History: Please list each disease (i.e. heart disease, cancer, stroke, diabetes, endometriosis, osteoporosis), and age if deceased:

Father: ____

Mother: ____

Brother(s): ____

Sister(s): ____

Maternal Aunt(s): ____

Maternal Grandmother: ____

Maternal Grandfather: ____

Social History:

- Do you smoke? ☐N ☐Y Number of packs/day? ______ Number of years? ______
- Do you drink alcohol? ☐N ☐Y More than 2 drinks/day? ☐N ☐Y If yes, amount? ______
- Do you exercise regularly? ☐N ☐Y Describe: ____
- What is your occupation? ____
- What are your hobbies? ____

HEALTH SCREENING

Have you had any of the following tests? If yes, please indicate year performed and results.

- Mammogram: ☐N ☐Y ____
- Osteoporosis (Bone Density)? ☐N ☐Y ____
- Colonoscopy (Colon Cancer Testing)? ☐N ☐Y ____
- Immunizations:
  - Gardasil (HPV)? ☐N ☐Y ____
  - Hepatitis A & B? ☐N ☐Y ____
- Hereditary Cancer Screening:

  Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Please mark below, if there is a **personal or family history** of any of the listed cancers. If yes, then **indicate family relationship** AND **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST & OVARIAN CANCER			You	Mother's side		Father's side		Siblings/children	
			Age DX	Relative	Age DX	Relative	Age DX	Relative	Age DX
Y	*N*	*Example*		*Grandmother*	65	Aunt Cousin	44 58	Sister	36
Y	N	Breast cancer							
Y	N	Ovarian cancer							
Y	N	Breast cancer in both breast OR multiple primary breast cancers							
Y	N	Are you of Ashkenazi Jewish descent?							

COLON & UTERINE CANCER			You	Mother's side		Father's side		Siblings/children	
			Age DX	Relative	Age DX	Relative	Age DX	Relative	Age DX
Y	N	Uterine (endometrial) cancer							
Y	N	Colon cancer							
Y	N	Ovarian, stomach, kidney/urinary tract, OR brain cancer							
Y	N	10 or more colon polyps found in a lifetime							

PHARMACY INFORMATION

Pharmacy: ______________________________________

Address: ____

____

Phone #: ______________________________________

Fax #: ____

____

Physician Signature