Women's Healthcare Physicians

New Patient Form

Name:_____ Date:___/____/_____ Birth Date:___/___/____

Referred By:_____ Age:_____

Reason for Your Visit: ___ Routine Physical

___ Problem Visit

Description of Problem: _____

_____

Personal History	Yes	No	Personal History	Yes	No
Anxiety			Other STDs		
Asthma			Heart Murmur		
Blood Transfusions			Heart Disease		
Bowel Disorders			Hepatitis/Jaundice		
Breast Cancer			High Blood Pressure		
Cancer			High Cholesterol		
Chronic Lung Disease			Kidney Stones		
Depression			Rheumatoid Arthritis		
Diabetes			Stroke		
Fracture			Tuberculosis – TB		
Glaucoma			Thyroid Disease		
Genital Herpes			Ulcers		
Genital Warts			Other:		
Gonorrhea/Chlamydia					
Please Explain:					

When was your last test or immunization?			
	Date		Date
PAP Smear		Flu Shot	
Mammogram		Gardasil	
Bone Density		Tetanus	
Colonoscopy		TB Skin Test	

Please list any operations or hospitalizations you have had			
Surgery/Reason	Date	Surgery/Reason	Date

Please list any medications/supplements you are currently taking			
Drug name	Dosage	Drug Name	Dosage
Allergies (medications, food, substances, Etc.?)			

Check if anyone in your immediate family has had:				
Illness	Yes	No	Relative	Age
Breast Cancer				
Cancer				
Depression/Anxiety				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Rheumatoid Arthritis				
Stroke				
Thyroid Disease				
Tuberculosis-TB				
Other:				

Your GYN History	
Do you use birth control? ____Yes _____No What method?	
What Age did you have your first period? _____age	
How long does your period last? _____days	Flow: Light Medium Heavy
Date of last period: ___/___/____	Do you have cramps? __Yes __No
Age of Menopause: _____	

Your OB History:			
	Number		Number
Total # of pregnancies		Miscarriages	
Full term births		Abortions induced	
Premature births		Living children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

#	Birth Date	Wks. Gest.	Baby's Weight	Sex	Deliv Type Vag/C-section	Comments/Complications
1						
2						
3						
4						
5						
6						

Social History
Do you smoke? ____Yes _____No Packs per day? _____packs Number of years? _____years
Do you drink alcohol? ____Yes ____No Number of drinks per day? _____drinks Number of drinks per week? _____drinks
Do you use any drugs? ____Yes ____No Type of drug? _____ Frequency? _____
Are you sexually active? ___Yes ___No Lifetime sexual partners: ___Less than 5 Do you have sex with : ____Men ____Women or ____Both ___More than 5
Any history of abuse: ____Yes ____No Type of abuse? ___Physical ___Emotional ___Sexual

Review of Systems

Please check if you have any of the following:

Constitutional _____Weight Loss _____Weight Gain _____Fatigue _____Night Sweats _____Hot Flashes	**Genitourinary** _____Loosing Urine _____Blood in urine _____Decreased Sex Drive _____Painful intercourse _____Genital Sores
Eyes _____Double Vision _____Vision Changes	**Skin** _____Rashes _____Itching _____Changes to lesions or moles
HEET _____Headache _____Dizziness _____Sinus Pain _____Nose Bleeding _____Thyroid Mass	**Neurological** _____Muscle weakness _____Seizures _____Memory problems _____Loss of balance _____Numbness or tingling
Breast _____Lumps _____Tenderness _____Nipple Discharge _____Abnormal Changes in breast	**Musculoskeletal** _____Joint pain or swelling _____Muscle pain _____Back pain
Cardiovascular _____Chest pain _____Irregular heart beat _____Swelling of legs	**Endocrine** _____Loss of hair _____Difficulty tolerating cold _____Difficulty tolerating heat
Respiratory _____Wheezing _____Cough _____Shortness of breath _____Spitting up blood	**Psychiatric** _____Anxiety _____Depression _____Insomnia _____Mood swings
Gastrointestinal _____Nausea _____Vomiting _____Diarrhea _____Constipation _____Abdominal pain _____Bloody/black stool	**Hematological** _____Bruising _____Cuts that do not stop bleeding _____Enlarged lymph nodes
Genitourinary _____Frequent Urination _____Pain with urination	**Other** _____ _____