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New Patient Information Form

Patient Name:___________________________________ Date:____________________

First day or year of last menstrual period?____
How is your period? (Check all that apply)
☐ Regular ☐ Irregular ☐ Painful ☐ Light ☐ Heavy ☐ Normal

How many hours of sleep do you get?___________ ____

How often do you exercise?
☐ Never ☐ Occasionally ☐ Weekly ☐ 3-4 Days/Week ☐ Daily

Do you perform monthly self-breast exams?____

Please list any medications that you are allergic to and your reaction:____________________________________
____
____

Please list any medications you are taking and dosage:____
____
____
____
____

Have you been pregnant?________________________
If so, how many times?___________________________
Number of vaginal deliveries:_____________________
Number of cesarean deliveries:____________________
Number of miscarriages:_________________________
Number of abortions:____________________________
Ectopic pregnancy:______________________________

Problem/Past medical history:____
____
____
____

Previous Surgeries (Including wisdom teeth):____
____
____
____
____

Social History:

Drug Use:	☐ Never	☐ Former	☐ Current	
Tobacco Use:	☐ Never	☐ Former	☐ Current	
Alcohol Use:	☐ None	☐ Occasionally	☐ Socially	☐ Daily
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widow
Sexual Activity:	☐ Currently	☐ Not Currently	☐ Never	
Sexual Preference:	☐ Heterosexual	☐ Homosexual		☐ Bisexual

Contraceptive: ☐ Oral ☐ Condoms ☐ None Other_______________

Health Maintenance: (Please put year of exam and result ex. Normal/Abnormal)

Last Pap:____

Last Mammogram:____

Last Colonoscopy:____

Last Bone Density:____

HPV Vaccine (Gardasil):____

If received, was it completed:____

Hepatitis "C" Screening:____

Last Flu Shot:____

Pneumonia Vaccine: ☐ Pneumovax ☐ Prevnar ☐ Both

If received, what year was your last pneumonia vaccine:________________________________

Family History: Please list Parents, Maternal/Paternal Grandparents, Maternal/Paternal Aunts and Uncles, and Siblings **ONLY**.

High Blood Pressure:____

____

____

Diabetes:____

____

____

Heart Attack:____

____

____

Stroke:____

____

____

Cancer (Please list which type):____

____

____

____

____

____

Please check (x) if you CURRENTLY have any of the following:

Fatigue	Abdominal Pain	GYN Symptoms
Fever	Bloating	
Weight gain	Bloody stools	Amenorrhea
Weight loss	Change in bowel habits	Bloody urine
Bruising	Constipation	Painful intercourse
Hair growth	Diarrhea	Painful urination
Hair loss	Difficulty swallowing	Frequent urination
Rash	Hemorrhoids	Hot flashes
Headache	Heartburn	Night sweats
Blurred vision	Nausea	Painful periods
Glaucoma	Vomiting	Pelvic pain
Visual loss	Back pain	Urine loss
Ring in the ears	Joint pain	Vaginal discharge
Vertigo	Muscle pain/weakness	Vaginal itching/burning
Nose bleed	Memory loss	Heavy periods
Hoarseness	Dizziness	Irregular periods
Sore throat	Loss of consciousness	Breast lumps
Sinus pain	Numbness	Breast pain/tenderness
Neck lumps	Seizures	Nipple discharge
Neck stiffness	Fainting spells	
Cough	Tremors	
Coughing up blood	Depression	
Shortness of breath	Insomnia	
Wheezing	Panic attacks	
Chest pain	Excessive thirst	
Ankle swelling	Easy bruising	
Irregular heartbeat	Suicidal thoughts	
Palpitations		