NEW BEGINNINGS™ OB-GYN

PATIENT HISTORY FORM

PAGE 1 (PLEASE PRINT CLEARLY)

PLEASE NOTE THAT THERE IS A SECTION ON PAGE 4 TO EXPLAIN OR ADD TO YOUR ANSWERS SHOULD YOU FEEL THIS IS NECESSARY.

Patient Name:	DOB:	Date:
Reason for your visit today:	How long have you had this problem?	

GYNECOLOGICAL HISTORY

First day of last period:	Do you have regular monthly periods? ☐ Yes ☐No	How often do your periods come?	Age at first period?
Are you in menopause? Yes No	When did you enter menopause? _____	Periods are: Mild ☐ Moderate Heavy	
Do you pass clots with your periods? Yes No	How many days do your periods last? _____	Cramps are: Mild Moderate Severe	
Current Birth Control Method:		Are you happy with this birth control? ☐ Yes ☐No	
Age at first intercourse:	Number of sexual partners (lifetime):	Sexual Preference: Heterosexual Homosexual Bisexual	
Have you had a new sexual partner since your last exam? ☐ Yes ☐No		Do you desire testing for STD's? ☐ Yes ☐No	
Last Pap Smear: ____/_____	Have you ever had an abnormal Pap? ☐ Yes ☐No	If yes, please give year and any procedures:	
Last mammogram: ____/_____	Have you ever had an abnormal mammogram? ☐ Yes ☐No	If yes, please give year and any procedures:	
Have you ever had any of the following sexually transmitted diseases? Chlamydia Gonorrhea Genital Warts Herpes HPV Syphilis Hepatitis B Hepatitis C HIV/AIDS		Do you perform monthly self breast exams? Yes No	

PREGNANCY HISTORY (Include miscarriages, terminations, and/or ectopic pregnancies)

Date (Month/Yr)	Gestational Age (Weeks)	Birth Weight	Sex M/F	Type of Delivery: Vaginal or C-Section	Preterm Labor: Yes/No	Comments/ Complications

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PAGE 2 (PLEASE PRINT CLEARLY)

Patient Name:	DOB:	Date:

MEDICAL HISTORY

Please check the box if YOU have had problems with any of following:

- ☐ Acne
- ☐ Other skin diseases
- ☐ Anemia
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Migraines
- ☐ Seizures/Epilepsy
- ☐ Stroke/TIA
- ☐ Lupus/+ ANA
- ☐ Other autoimmune disease

- ☐ High cholesterol
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Asthma
- ☐ Pneumonia
- ☐ COPD
- ☐ Other lung disease
- ☐ Breast lump
- ☐ Breast discharge
- ☐ Breast surgery
- ☐ Breast biopsy
- ☐ Blood clots (DVT)
- ☐ Pulmonary embolus
- ☐ Bleeding problems
- ☐ Blood transfusions

- ☐ Gallbladder disease
- ☐ Hepatitis (any)
- ☐ Irritable bowel syndrome
- ☐ Gluten insensitivity
- ☐ Acid reflux/GERD
- ☐ Stomach ulcer
- ☐ Ulcerative colitis/Crohn's
- ☐ Kidney infections
- ☐ Recurrent bladder infection
- ☐ Overactive bladder
- ☐ Urinary incontinence
- ☐ HIV/AIDS
- ☐ Depression
- ☐ Anxiety
- ☐ Other psychiatric problems

- ☐ Broken bones
- ☐ Osteoporosis/bone loss
- ☐ Arthritis
- ☐ Joint problems
- ☐ Scoliosis
- ☐ Recurrent vaginal infections
- ☐ Pelvic infections
- ☐ Abnormal Paps
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Ovarian tumors/cysts
- ☐ Other_____

_____

_____

_____

_____

SURGERIES AND HOSPITALIZATIONS (LIST ALL EXCEPT PREGNANCIES)	DATE OF SURGERY OR HOSPITALIZATION

ARE YOU ALLERGIC TO ANY MEDICATIONS? (Please also list food and major environmental allergies)

Name of medication	Reaction

ARE YOU ALLERGIC TO LATEX? YES NO

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PAGE 3 (PLEASE PRINT CLEARLY)

Patient Name:	DOB:	Date:

SOCIAL HISTORY

DO YOU CURRENTLY:

Exercise regularly? Yes No
How many times per week_____
What type of exercise_____

Drink alcohol? Yes No
If so, how much? _____

Use recreational drugs? Yes No

Smoke cigarettes? _____ packs/day
For how many years? _____

Are you a FORMER smoker? Yes No
How long ago did you quit? _____

MEDICATIONS/HERBAL SUPPLEMENTS/VITAMINS

Name of Medication	Dose	Why Taking?

FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Please check all that apply under the appropriate family member:

Disease/Condition	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Other
Alcoholism/Drug Abuse									
Anemia									
Arthritis									
Asthma/Lung Problems									
Birth Defects									
Bleeding Problems									
Blood Clots									
Bloody Stools/Colon Polyp(s)									
Breast Cancer									
Colon Cancer									
Depression/Anxiety									
Diabetes									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Kidney Disease/UTI's									
Liver Disease									
Mental Illness									
Osteoporosis/Bone Loss									
Ovarian Cancer									
Seizures									
Stroke									
Thyroid Disease									
Tuberculosis									
Uterine Cancer									

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PATIENT HISTORY FORM

PAGE 4 (PLEASE PRINT CLEARLY)

Patient Name:	DOB:	Date:

GENETIC HISTORY (PREGNANT PATIENTS ONLY)

Please indicate if ANY of these conditions apply to you, the father of your baby, or ANY family members of you the father of your baby

NAME OF CONDITION	YES	NO	RELATIONSHIP OF AFFECTED PERSON TO YOU
Down Syndrome (Trisomy 21)			
Other Chromosome Abnormality			
Heart Defect/Hole in Heart Present at Birth			
Cleft Lip/Cleft Palate			
Spina Bifida (Neural Tube Defect)			
Cystic Fibrosis			
Tay-Sachs Disease			
Gaucher Disease			
Niemann-Pick Disease			
Muscular Dystrophy			
Spinal Muscular Atrophy			
Bone/Skeletal Defects			
Polycystic Kidney Disease			
Hemochromatosis			
Mental Retardation			
Fragile X Syndrome			
Other Conditions (please describe)			

ADDITIONAL INFORMATION/EXPLANATION OF ANSWERS

Please use this area to explain any responses to previous sections or add any additional information you think may be helpful. You may also use this space to continue your responses to any other sections.