Woman to Woman Gynecology, PLLC

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New Patient Information Form

Name:_____ Age:_____
DOB:_____ Chart:_____
Referring Physician:_____ Primary Care Physician:_____ Trying to conceive? Yes No If so how long (Years and months)?_____
Date last pap:_____ Result:_____ Date last mammogram:_____
Date last colonoscopy:_____ Result:_____ Recommended f/u(years):_____
Date last bone density:_____ Result:_____

Menstrual History: Age at first menses:_____ Date of last period:_____ Normal? _____ Frequency menses:_____ Length of menses:_____ #Heavy: _____ How often do you need to change a pad/tampon?_____ Clots?_____
Cramps? Mild/Mod/Severe PMS? Mild/Mod/Severe Assoc. symptoms: nausea vomiting headaches diarrhea irritability food cravings

Gynecological History: (Circle Response)

Abnormal pap	yes	no	Leak of Urine	yes	no
Acne	yes	no	Mycoplasma	yes	no
Breast Discharge	yes	no	Ovarian Cysts	yes	no
Breast Lump	yes	no	Painful Intercourse	yes	no
Brown Bleeding	yes	no	Pelvic Adhesions	yes	no
Chlamydia	yes	no	Pelvic Infection	yes	no
Decreased Libido	yes	no	Pelvic Pain/Cramps	yes	no
Douche	yes	no	Physical Abuse	yes	no
Endometriosis	yes	no	Previous IUD Use	yes	no
Exposure to DES	yes	no	Sexual Abuse	yes	no
Fibroids	yes	no	Spotting	yes	no
Gonorrhea	yes	no	Urinary Frequency	yes	no
Herpes	yes	no	Urinary Urgency	yes	no
Hot flashes	yes	no	Use of Lubricants	yes	no
Lack of Arousal	yes	no	Vaginal/Vulvar Pain	yes	no
Lack of Orgasm	yes	no			

Social History:
Alcohol Use: yes no type:_____ #/day:_____ #/week:_____
Caffeine Use: yes no type:_____ #/day:_____ #/week:_____
Tobacco Use: yes no type:_____ #/day:_____
Recreational drug use ever: yes no type:_____ How often:_____
Recreational drug use current: yes no type:_____ How often:_____
Regular exercise: yes no type:_____ days/week:_____
Occupation:_____

Marital status: M S W D (circle all that apply) Years together:_____

Partner's name:_____ Age:_____
Occupation:_____

Ancestral Background: (certain illness and genetic disorders are more common in particular ancestral backgrounds)

□African	□French Canadian	□Latin American	□Ashkenazi Jewish
□Mediterranean	□Native American	□Caribbean	□Sephardic Jewish
□Asian	□Indian		
	□Other:_____		

General Symptoms: (circle if current problem)

Acid Reflux	Cough/breathing problems	Fainting	Memory problems
Allergies	Depression	Fatigue	Mouth sores
Anxiety	Diarrhea	Food cravings	Muscle pain/ache
Blood in stool	Dizziness	Food intolerance	Nausea/vomiting
Bowel cramping	Dry eyes	Hair loss	Numbness hands/feet
Brittle nails	Dry hair	Headache	Palpitations
Chest pain	Dry skin	Heat intolerance	Tongue sores
Clumsiness	Easy bleeding	Insomnia	Vision problems
Cold intolerance	Easy bruising	Joint pain	Weight gain > 10lbs
Constipation	Excessive thirst	Low sugar	Weight loss > 10lbs

Other:_____
_____

Medical History:
Autoimmune:_____

Infections:_____
Bladder:_____ _____

Kidney:_____
Blood:_____ _____
Liver:_____
_____
Cancer:_____

Lungs:_____
Diabetes (type and years):_____

Mental:_____
Ears:_____

Neurologic:_____
Eyes:_____

Nose:_____
Gastrointestinal:_____

Skin:_____

Heart:_____

Thyroid:_____
Other:_____
_____

Surgical History: (include surgery, date, and where preformed)
_____
_____
_____
_____
_____

Family History: (include chronic illness, cancer, genetic disorder, bleeding/clotting disorder, pregnancy/gyn problems, etc.)

Maternal Grandmo.:_____ Paternal grandma.:_____
Maternal Grandfa.:_____ Paternal Grandfa.:_____
Mother:_____

Father:_____
Sisters:_____
_____
Brothers:_____
_____
Children:_____
_____
Aunts:_____
_____
Uncles:_____
_____
Other:_____
_____

Pregnancy History:
Total pregnancies:_____ Term births:_____ Preterm births:_____
Induced abortions:_____ Miscarriages: _____ Adopted children:_____
Did you breast feed?:_____ Breast feeding currently?:_____
Complications:_____
_____

Contraceptive Use:(include type, when used, why discontinued, includes tubal and/or vasectomy)
_____
_____
_____
_____
__

Do you use natural family planning: Yes No
Type:_____

Current Medications: (**include prescription, over-the-counter, vitamins, and supplements**)

Medication	Dose/frequency	Reason for use

Allergies: (include medication and reaction)

Medication	Reaction