Gallatin Women's Center

New Patient History

Today's Date / /

I. Identification Date (Please Print)

Name:______________________ Age:______ Race:______________ Marital Status______________

Sexual Orientation:____

Occupation:____________________ Work Phone:________________ Home Phone:________________

Referred By :______________________________ Religion affiliation: ________________

Husband's Name:______________________________ Age:_____ Occupation: ________________

II. Reason for seeing Doctor:

____

____

III. Medical History: Answer these questions by checking the appropriate boxes.

FOR PHYSCIANS USE ONLY

Have you or any of your family ever had:	YES	NO
1. Headaches or a nervous disorder		
2. A thyroid problem		
3. A heart condition or high blood pressure		
4. A lung disorder		
5. Breast problems		
6. jaundice, hepatitis, or other liver disorders		
7. Stomach, bowel, or gallbladder problems		
8. Kidney or bladder problems		
9. Female or sexual problems		
10. Allergies or drug sensitivities		
11. Anemia or blood disorders		
12. A blood transfusion		
13. Diabetes		
14. Cancer		
15. Birth defects or inherited diseases		
16. Other medical problems		
17. No known medical problems		
18. Do you smoke		
19. Are you sexually active		

IV. Hospitalizations: Please list those operations or serious illness that you have had that have required hospitalizations .

Mo/Yr	Illness or Operation	Complications Yes/No
1.		
2.		
3.		
4.		
5.		

V. Pregnancy History: Please list the number of
Pregnancies _____ Full Term _____ Premature Births ____
Miscarriages _____ abortions _____ Living Children _____

	Born Mo/Day/Yr	Sex (M/F)	Normal or C/S	No. of weeks pregnant	Birth Weight	Complications Y/N
1.						
2.						
3.						
4.						
5.						

Patient Signature: ____ Date:______________