New Patient History Form

Patient Name_____

Past Medical History: Please circle all of the following conditions that you have or have had in the past.

- ☐ Cancer- BRCA Tested
- ☐ Cancer-Breast
- ☐ Cancer-Cervical
- ☐ Cancer-Colon
- ☐ Cancer-Endometrial
- ☐ Cancer-Lung
- ☐ Cancer-Other
- ☐ Cancer-Ovary
- ☐ Cancer-Skin
- ☐ Cancer-Vaginal
- ☐ Cancer-Vulvar
- ☐ Cardiac-Heart Arrhythmia
- ☐ Cardiac-Heart Disease
- ☐ Cardiac-High Blood Pressure
- ☐ Cardiac-High Cholesterol
- ☐ Cardiac-Other
- ☐ Derm.-Acne
- ☐ Derm.-Eczema/Psoriasis
- ☐ Derm.-Other
- ☐ ENT-Hearing
- ☐ ENT-Other
- ☐ Endo.-Diabetes/Hx of Gestational Diabetes
- ☐ Endo.-Elevated Prolactin
- ☐ Endo.-Osteopenia
- ☐ Endo.-Osteoporosis
- ☐ Endo.-Other
- ☐ Endo.-Thyroid Problems
- ☐ Eyes-Cataracts
- ☐ Eyes-Glaucoma
- ☐ Eyes-Other
- ☐ Eyes-Vision Loss/Macular Degeneration
- ☐ GI-Colon Polyps
- ☐ GI-Crohn's/Ulcerative Colitis
- ☐ GI-Gallbladder Disease
- ☐ GI-Hemorroids
- ☐ GI-Irritable Bowel Syndrome
- ☐ GI-Liver Disease/Hepatitis
- ☐ GI-Other
- ☐ GI-Reflux/Stomach Ulcers
- ☐ GI-Vitamin Deficiency
- ☐ Hematology-Anemia
- ☐ Hematology-Bleeding Disorder
- ☐ Hematology-Blood Clotting Disorder/ Factor V Leiden
- ☐ Hematology-Blood Transfusion
- ☐ Hematology-DVT/Pulmonary Embolism
- ☐ Hematology-Other
- ☐ ID-Chicken Pox/ Shingles
- ☐ ID-HIV
- ☐ ID- MRSA
- ☐ ID-Other
- ☐ ID- Rheumatic Fever
- ☐ ID- Tuberculosis/ Positive PPD
- ☐ ID- Usual childhood diseases- Chicken Pox
- ☐ Neuro-Headaches/Migraines
- ☐ Neuro-Memory Loss/ Dementia
- ☐ Neuro-Neuropathy
- ☐ Neuro-Other
- ☐ Neuro-Seizures/Epilepsy
- ☐ Neuro-Stroke/TIA
- ☐ Ortho-Chronic Back Pain
- ☐ Ortho-Degentve. Joint Disease
- ☐ Ortho-Fractures
- ☐ Ortho-Other
- ☐ Psych-ADD
- ☐ Psych-Anxiety Disorder
- ☐ Psych-Bipolar Disease
- ☐ Psych-Depression
- ☐ Psych-Eating Disorder
- ☐ Psych-Other
- ☐ Psych-PMS/PMDD
- ☐ Pulmonary-Asthma
- ☐ Pulmonary-COPD/Emphysema
- ☐ Pulmonary-Other
- ☐ Pulmonary-Seasonal Allergies/ Allergic Rhinitis
- ☐ Pulmonary-Sleep Apnea
- ☐ Rheumatology-Arthritis
- ☐ Rheumatology-Autoimmune Disease
- ☐ Rheumatology-Fibromyalgia/ Chronic Pain
- ☐ Rheumatology-Other
- ☐ Rheumatology-Restless Leg Syndrome
- ☐ Urology-Frequent Urinary Tract Infections
- ☐ Urology-Hematuria(Blood in Urine)
- ☐ Urology-Interstitial Cystitis
- ☐ Urology-Kidney Disease
- ☐ Urology-Kidney Stones
- ☐ Urology-Other
- ☐ Urology-Urinary Incontinence
- ☐ Wt Management-Obesity
- ☐ Wt Management-Other

Surgical History: Have you ever had any surgery (including oral surgery, tonsils, abdominal surgery, etc.)?

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

Medications (include prescriptions, over-the-counter medications, vitamins, supplements, etc.)

_____

_____

Vaccines

HPV Yes / No Did you complete all three shots of the series? Yes / No _____

Other vaccines (please list) _____

Pharmacy Name/Address: _____ Phone #_____

Allergies

Are you allergic to any medicines? Yes / No If yes, please explain:

Medication	Reaction	Onset Date

turn over to back of page →

Social History:

Do you smoke or use tobacco? Never Former Every day Some days How much? _____ How long? _____

Occupation: _____ Education Completed_____

Marital Status: Married Single Divorced Separated Widowed Domestic Partner

Are you sexually active? Yes / No

Do you drink alcohol? Yes / No If yes, how much? Occasional Moderate Heavy Years of use _____

Do you use "recreational" drugs? Yes / No If yes, how much? Occasional Moderate Heavy Years of use _____

Do you drink caffeine? Yes / No If yes, how much? Occasional Moderate Heavy

What is your diet? Regular Vegetarian Vegan Gluten Free Carbohydrate Cardiac Diabetic Other_____

How much do you exercise? None Occasional Moderate Heavy What is your general stress level? Low Medium High

Sexual Orientation: Heterosexual Homosexual Bisexual Domestic Violence? Yes / No

Is blood transfusion acceptable in an emergency: Yes / No

Family History: Please list any problems that your immediate family member(s) has/had:

_____ Relation_____ Onset Age_____ Died of Age_____

_____ Relation_____ Onset Age_____ Died of Age _____

_____ Relation_____ Onset Age_____ Died of Age _____

_____ Relation_____ Onset Age_____ Died of Age _____

Gynecological History

First day of your last period_____ Age at first period_____ Age you delivered your first child_____

How often do you start your period? Monthly Less than 21 days More than 35 days Very irregular

Flow of your periods: Light Moderate Heavy # days of bleeding _____ Cramps? Yes / No

Are you Post-Menopausal? Yes / No If yes, what age onset?_____

Have you used hormones for menopause? Current Past Never If yes, how long?_____

Are you using contraception?	Yes / No	Type? Are you satisfied with this method? Yes / No
Are you currently sexually active?	Yes / No	Total Lifetime Partners? Less than 5 / More than 5
Have you ever had an STD-PID?	Yes / No	Yes? Which ones?

	Date	Results	History of abnormal?	Describe
Pap Smear		Normal / Abnormal	Yes / No	
Mammogram		Normal / Abnormal	Yes / No	
Endometrial Bx		Normal / Abnormal	Yes / No	
Ultrasound		Normal / Abnormal	Yes / No	
Vulvar Bx		Normal / Abnormal	Yes / No	
Colonoscopy		Normal / Abnormal	Yes / No	
DEXA Scan		Normal / Abnormal	Yes / No	

Do you have a history of any of the following? If yes, please circle.

Breast Problems Cervical Dysplasia Endometriosis Fibroids Ovarian Problems Polycystic Ovarian Syndrome Infertility

Obstetrical History

Total # of Pregnancies _____ # Vaginal deliveries _____ # Cesarean deliveries _____

Living Children_____ # Full term_____ # Preterm_____ # Miscarriage/Abortion_____

Submit