Print Form

# New Patient Obstetrics & Gynecology Form

This will become part of your medical record. Today's Date:

Name: Date of Birth: Age:

Primary Care Physician: Telephone:

Pharmacy: Pharmacy Address:

## Menstrual History:

First day of last menstrual period

Age at first menstrual period years

Number of days from the start of one period to the start of the next days

Number of days that you bleed days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day?

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? years

Have you had bleeding or spotting since your periods stopped? Yes ☐ No ☐

## Contraceptive and Sexual History:

Present birth control method:

Birth control methods used in the past:

| | METHOD | LENGTH OF USE | REASON FOR DISCONTINUATION |
|---|---|---|---|
| 1) | | | |
| 2) | | | |

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Have you had a new sexual partner in the past three months? Yes ☐ No ☐

How many sexual partners have you had in the past 3 months?

Is/Are your partner(s) male, female, or both? Male ☐ Female ☐ Both ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Would you like to discuss sexual activity or birth control today? Yes ☐ No ☐

## Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes ☐ No ☐

Last Pap Smear

Last Mammogram

Last Bone Density (DEXA)

Last Colonoscopy

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

Abnormal Pap Smears Yes ☐ No ☐

Sexually transmitted diseases Yes ☐ No ☐

List:

Fibroids Yes ☐ No ☐

Endometriosis Yes ☐ No ☐

Infertility Yes ☐ No ☐

Urinary incontinence Yes ☐ No ☐

**Obstetrical History:** Please record the number of:

Pregnancies ☐ Vaginal Births ☐ Ectopics ☐ Abortions ☐
Living Children ☐ C-Sections ☐ Miscarriages ☐

List any complications of pregnancies ☐

**Medical History:** Please check if you or a blood-relative have had any of the following:

| | MYSELF | FAMILY | | MYSELF | FAMILY | | MYSELF | FAMILY |
|---|---|---|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | Mental Illness | ☐ | ☐ | Liver Disease / Hepatitis | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Depression | ☐ | ☐ | Gall Bladder Disease | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | Anxiety | ☐ | ☐ | Blood clots in veins/lungs | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Eating disorder | ☐ | ☐ | Blood Transfusion | ☐ | ☐ |
| Stroke | ☐ | ☐ | Migraine Headaches | ☐ | ☐ | Breast Cancer | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Urinary Tract Infection | ☐ | ☐ | Colon Cancer | ☐ | ☐ |
| COPD / Emphysema | ☐ | ☐ | Lupus | ☐ | ☐ | Uterine Cancer | ☐ | ☐ |
| Asthma | ☐ | ☐ | Arthritis | ☐ | ☐ | Ovarian Cancer | ☐ | ☐ |
| Seizures | ☐ | ☐ | Back Injury | ☐ | ☐ | Other Cancer, specify: | | |
| Thyroid problems | ☐ | ☐ | Osteoporosis | ☐ | ☐ | | | |

Other Medical Problems (list all):

**Surgical History:** Please list any operations, including the year, or your age when you had it:

**Personal / Social History:**

Occupation ☐ Marital Status ☐

Do / Did you use tobacco products? Yes ☐ No ☐ How much? ☐

Do / Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? ☐

Do / Did you use illicit/street drugs? Yes ☐ No ☐ Which drugs? ☐

Have you ever been tested for HIV? Yes ☐ No ☐ Year and result: ☐

Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes ☐ No ☐

**Medications:** Please list any medications you take, including over-the-counter medicines

| MEDICINE | DOSE | HOW OFTEN | MEDICINE | DOSE | HOW OFTEN |
|---|---|---|---|---|---|
| | | | | | |

Please list any allergies to medications: ☐

**Current Medical Concerns:** Please circle if you have had any of the following this week: ☐

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Weight change | Yes | No | Nausea / Vomiting | Yes | No | Trouble sleeping | Yes | No |
| Abnormal bleeding | Yes | No | Bowel changes | Yes | No | Night sweats / Hot flashes | Yes | No |
| Abnormal hair growth | Yes | No | Anxiety / Panic | Yes | No | Breast problems | Yes | No |
| Problems with urination | Yes | No | Depression | Yes | No | | | |

How did you hear about us? ☐

Is there any other information you feel we should have?

Patient Signature Date

Provider Signature Date