New Patient Form

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.

Today's Date _____

Legal Name _____ Date of Birth _____

Who is your Primary Care Provider or other Doctors? _____ □ None

Reason for Your Visit today: _____

MEDICATION ALLERGIES

*Latex Allergy? □ YES □ NO

ALLERGY	REACTION	ALLERGY	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

It is now possible to electronically access your active prescription medications list directly from the pharmacy, and the nurse will review this information with you.

M*ay we access your medication list?* □ YES □ NO

_____

_____

GYNECOLOGIC HISTORY

(please list the approximate date that you had each of the following)

Mammogram ___N/A _____Most Recent Date
Colonoscopy ___N/A _____Most Recent Date
Bone Density ___N/A _____Most Recent Date
Pap Smear ___N/A _____Most Recent Date

Have you had the entire HPV vaccine series (Gardasil) ___Yes ___No
Have you ever had an abnormal pap smear ___Yes ___No
Do you have a history of cervical or vulvar dysplasia ___Yes ___No
Are you currently sexually active ___Yes ___No
Have you ever had a sexually transmitted infection ___Yes ___No
Sexual Orientation: Heterosexual / Homosexual / Bisexual
Other/ Do not wish to state

Do you have a history of:
Endometriosis? ___Yes ___No
Uterine Fibroids? ___Yes ___No
Infertility? ___Yes ___No
Recurrent Ovarian Cysts? ___Yes ___No
Polycystic Ovarian Syndrome? ___Yes ___No
Dysmenorrhea (Painful periods)? ___Yes ___No

FIRST DAY of your most recent menstrual period _____

Are you using a method to prevent pregnancy? __Yes __No
Method: _____

At what age did you have your first period? _____

If menopausal, age you were when you had your last period _____

Post-menopausal hormone use?
Never / Past Use / Current Use

How often do you have a period?
_____

PREVIOUS BIRTHS / MISCARRIAGES / TERMINATIONS / ECTOPIC PREGNANCIES / ADOPTIONS

Delivery Date	Type of Delivery	Sex (M/F)	Baby's Weight	Gestational Age (weeks)	Complications during Pregnancy or Delivery

FAMILY HISTORY (please check which family member had these problems) □ I was adopted □ Unknown

	M	F	S	B	*Please specify mother or father's side of family for Aunts, Uncles and Grandparents
High Blood Pressure					
Stroke					
Heart Disease					
Osteoporosis					
Diabetes					
Psychiatric Disorders					
Breast Cancer					
Ovarian Cancer					
Cervical Cancer					
Uterine Cancer					
Colon Cancer					
Pancreatic Cancer					
Prostate Cancer					
Other Cancers					

SOCIAL HISTORY

How much do you exercise in a week? None / Occasional / Moderate / Heavy
How much alcohol do you drink on average? None / Occasional / Moderate / Heavy
Do you smoke tobacco (i.e. cigarettes)? Never / Former / Current
Do you use chewing tobacco? Never / Former / Current
Do you smoke smokeless tobacco? Never / Former / Current
Do you vape or use e-cigarettes? Never / Former / Current
Do you use street drugs or narcotics regularly? ___Yes ___No; Type: _____
Do you use a marijuana product of any kind? ___Yes ___No

What do you do for a living? _____ Are you retired ___Yes ___No
Highest Level of Education completed? _____
Marital Status: Single / Engaged / Married / Divorced / Widowed / Domestic Partner / Separated
Do you eat a special diet (i.e. vegetarian, etc) ___Yes ___No; If yes, type: _____
What is your general stress level? Low / Medium / High
How much caffeine do you have on average? None / Occasional / Moderate / Heavy

SOCIAL HISTORY, CONTINUED

Do you have any guns in your home? ___Yes ___No
Do you use a seatbelt every time you are in the car? ___Yes ___No
Do you have a working smoke alarm in your home? ___Yes ___No
In an emergency, may you be given a blood transfusion? ___Yes ___No

Have you ever felt threatened or been abused by anyone? ___Yes ___No
If yes, when and by whom: _____
Have you ever had any unwanted sexual experiences? ___Yes ___No
Do you have a religious preference? _____

SURGERIES (please list any surgery you have ever had—*attach extra page if needed*)

DATE	SURGERY

YOUR MEDICAL HISTORY

___ Cancer _____	___ Gallbladder Disease	___ Chronic Back Pain
___ Heart Arrhythmia	___ Hemorroids	___ ADD
___ Heart Attack	___ Irritable Bowel Syndrome	___ Anxiety
___ Heart Disease	___ Liver Disease/Hepatitis	___ Bipolar
___ Heart Murmur	___ Reflux/Ulcers	___ Depression
___ High Blood Pressure	___ Anemia	___ Eating Disorder
___ High Cholesterol	___ Bleeding Disorder	___ PMS/PMDD
___ Acne	___ Blood Transfusion	___ Asthma
___ Eczema/Psoriasis	___ DVT/Pulmonary Embolism	___ COPD/Emphysema
___ Hearing Loss	___ Tuberculosis	___ Sleep Apnea
___ Seasonal Allergies	___ Chicken Pox/Shingles	___ Autoimmune Disease
___ History of Gestational Diabetes	___ HIV	___ Fibromyalgia/Chronic Pain
___ Hyperthyroidism	___ MRSA	___ Interstitial Cystitis
___ Hypothyroidism	___ Kidney Disease	___ Recurrent UTI's
___ Osteopenia	___ Dementia	___ Kidney Stones
___ Osteoporosis	___ Headaches/Migraines	___ Urinary Incontinence
___ Glaucoma	___ Seizures/Epilepsy	___ Aneurysm
___ Colon Polyps	___ Stroke/TIA	___ Obesity
___ Crohn's Disease/Colitis (UC)	___ Arthritis	___ Diabetes, Type 1 or 2