

Women Gynecology & Childbirth Associates, P.C.

New Patient History Sheet

Established Patient No History in EMR

Name: _____ Date of Birth: _____ Today's Date: _____

Name you prefer to be called: _____

Age: _____ Preferred Pharmacy: _____

Primary care doctor: _____

What is the reason for your appointment today?

Yearly Exam/Pap smear

Other: _____

What is your LMP (Last menstrual period): _____ Menopausal YES NO

What questions do you have for your health care provider today?

Which prescriptions do you need refilled today?

List all medications/vitamins that you are taking:

Please list all medications you are ALLERGIC to:

Do you have a LATEX ALLERGY? YES NO

Please check if YOU are being treated or have been treated for any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid disease |

Other: _____

Please check if YOU have had any of these surgeries or treatments:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> C-section (#: ____) | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Back/neck surgery | <input type="checkbox"/> D&C | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Bowel surgery | <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Uterine ablation | <input type="checkbox"/> Ovarian surgery |

Other: _____

Please tell us about your gynecologic history:

Age at first period: _____ Regular cycles: Yes No Usual length of flow: _____

Age of menopause: _____ Hormone Replacement Therapy: Yes No

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Polycystic ovaries |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Heavy periods |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Treatment for abnormal Pap: | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> LEEP |
| <input type="checkbox"/> Cryo (freezing) | <input type="checkbox"/> Other | | |

Please tell us about your pregnancies:

of pregnancies: _____ # of deliveries: _____ # of miscarriages: _____
of abortions: _____ # of children living: _____

Are you? Single Married Divorced Widowed Separated

Who do you live with? _____

Your occupation: _____ Retired YES NO

Are you being physically, sexually or emotionally abused? No Yes

How much do you?

Smoke None Quit _____ packs per day

Drink Alcohol None Occasionally Daily

Drug use None Yes- list drugs used: _____

Do you exercise? No Yes, how often _____

Do you perform breast self exams? No Yes

Do you use seat belts? No Yes

Do you have a health care proxy? No Yes

Do you take Calcium/vitamin D? No Yes Multivitamin/folate? No Yes

Sexually active: No Yes If yes, Male Female Both

Do you want an HIV test? No Yes Other STD testing? No Yes

Current contraception use (methods): _____

Have you had Measles-Mumps-Rubella vaccine? No Yes

If you are less than 26 years old, have you received the HPV vaccine? No Yes

Please check if anyone in your immediate FAMILY (parents, siblings) ever had the following:

Breast cancer High blood pressure Thyroid disease

Colon cancer Heart disease Blood clots

Ovarian cancer Diabetes Stroke

Uterine cancer Osteoporosis/osteopenia High cholesterol

Other: _____

When was your last ----? List the year.

Pap smear: _____

Tetanus shot: _____

Mammogram (if over 40 years old) _____

Colonoscopy (if over 50 years old) _____

Bone Density (if in menopause) _____

Cholesterol check (if over 40 years old) _____

Are you having any CURRENT problems with ----? (Please circle those that apply-ONLY IF CURRENT)

General: weight gain weight loss fatigue fever

HEENT: headache bleeding gums blurry vision

CV: chest pain palpitations irregular heart beat

Resp: cough shortness of breath wheezing

GI: nausea vomiting abdominal pain diarrhea constipation unusual bloating rectal bleeding

GU: pain with urination incontinence frequent urination abnormal vaginal discharge pelvic pain

Musculoskeletal: swelling in joints pain in joints

Skin: rash change in moles abnormal lumps/bumps

Breast: breast pain spontaneous nipple discharge skin changes breast lump

Neurologic: fainting numbness weakness

Psychiatric: depression anxiety poor sleep impaired memory other mood changes

Endocrine: sweating increased thirst increased urination

Heme: easy bruising easy bleeding

If menopausal: night sweats hot flashes vaginal dryness poor sleep

Would you like a chaperone today? We would be happy to provide one. No Yes

**Due to numerous changes by insurance companies, you may be financially responsible for the lab tests and additional services provided at your visit today. Patient Signature: _____ Date: _____