



New Patient History Form
Obstetrics & Gynecology

Name _____ Age _____ Today's Date _____
first middle last

Occupation _____ Marital Status: Single Married Divorced Widowed

What is the purpose of your visit? _____

Referred to our office by: _____

If you have a specific problem, please describe briefly: _____

How long have you had this problem? _____

Have you consulted anyone else? Yes No Who? _____

Describe any previous testing and/or treatment: _____

Please list all medications you are currently taking. Please include over the counter medications and herbal supplements. _____

Please list all allergies to medications, latex, foods: _____

GYNECOLOGY REVIEW

Last Pap Smear _____ Last Mammogram _____ Last Bone Density _____

Date last period began: _____ Age your period began: _____

How often does your period come? Less than 20 days apart 21-30 days apart 30-40 days apart
 greater than 40 days apart

How many days do you usually flow? Less than 2 2-7 7-10 more than 10

I use _____ pads/ _____ tampons on my heaviest days
how many? how many?

Do you stay in bed during your period? Yes No

Do you bleed or spot between periods? Yes No

Do you bleed or spot after intercourse? Yes No

Do you require additional overnight protection? Yes No

Do you have significant pain with your period? Yes No

If yes, what do you usually take? _____ Dosage? _____

What form of birth control do you use?

- Birth control pills – Name _____ for how many yrs./mos. _____
- IUD Type/date of insertion _____ Vasectomy _____
- Diaphragm _____ Rhythm/Natural Family Planning _____
- Condoms/Foam/Suppositories _____ Tubal Ligation _____
- Menopause _____ Hysterectomy _____
- Not sexually active _____ Other: _____

Have you reached Menopause? Yes No Age of onset: _____

Do you have hot flashes? Yes No Night sweats? Yes No

Vaginal dryness/painful intercourse? Yes No Trouble sleeping? Yes No

Have you taken hormone replacement therapy? Yes No

Medication taken _____

Duration of treatment _____

Reason for discontinuing? _____

Herbal or natural supplements _____

Do you have pain during or after intercourse? Yes No

Do you have any concerns with sexual function/desire? Yes No

Do you have concerns with PMS? Yes No

Do you perform monthly breast self-exams? Yes No

Any significant breast changes that you have noticed? _____

Do you have: breast lumps nipple discharge breast tenderness

Fibrocystic breast changes _____

Do you have a chronic vaginal discharge? Yes No _____

Have you used medication for the discharge? Yes No Medication used: _____

Do you douche? Yes No If so, how often? _____ What do you use? _____

Have you been treated in the past for a vaginal infection? Yes No

Yeast Chlamydia HPV/genital warts Trichomonas

Gardnerella Herpes/HSV virus Gonorrhea Syphilis

Pelvic Inflammatory Disease Bacterial/BV

Have you ever had an abnormal pap smear? Yes No What year? _____

Describe any treatment/follow-up: _____

Burning on urination? Yes No

Blood in the urine? Yes No

Urinary tract infection? Yes No

How many infections? _____

Urinary frequency? Yes No

Urinary urgency? Yes No

Do you get up at night to urinate? Yes No How many times?_____

Do you wet yourself when you cough/laugh/exercise? Yes No

Have you seen a Urologist in the past? Yes No

Do you wear pads for urinary leakage? Yes No

SOCIAL HISTORY

Do you consume caffeine daily? Yes No Coffee/Tea_____servings/day

Chocolate_____servings/day Carbonated soft drinks_____servings/day

Do you consume alcohol on a regular basis? Yes No Drinks/week_____

Do you smoke? Yes No How much?_____

Have you smoked cigarettes in the past? Yes No When quit?_____

Have you used illicit or IV drugs in the past? Yes No What?_____

OBSTETRICAL HISTORY

Please list pregnancies, miscarriages, and terminations from past to current:

Date	Length	D&C	Vaginal	C-Section	Infant	Weight	Complications

SURGERIES AND HOSPITALIZATIONS

List all except obstetrical: *(Use a separate piece of paper if more space is needed)*

Surgery/Hospitalization	Date	Reason/Diagnosis

