

## 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 \_\_\_\_\_