NEW PATIENT INFORMATION FORM

NAME ____ **DOB** ________________ **AGE** __________ **DATE** ____________

Which doctor are you seeing? ______________________________ Appointment Date: _____________________

Are you new to this practice? Yes _____ No _____

Race: African American/Black_____, American Indian/Alaskan Native _____, Asian _____, Caucasian/White _____, Pacific Islander/Native Hawaiian _____, Other _____, Declined _____
Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Reason for today's visit: ____

Local Pharmacy Name: ___________________________________ **Pharmacy phone:** ____________________________

Mail Order Pharmacy: _____________________________________ **Phone**: ____________________________________

ALLERGIES:
Drug: ____________________________________ **Food**: ____________________________________
Latex Allergy: Yes _____ No _____

Physician who referred you: ___________________________________
Primary Care Provider: ______________________________________
Other Care providers: (please specify specialty) ____

OBSTETRICAL HISTORY: (Please list all past pregnancies and their outcomes) ***NEVER been pregnant, please check _____**

Date of Delivery (MDY)	Type (Vaginal, C-section, miscarriage, abortion)	Baby Weight/Sex	Complications
_____/______/____	____	___________________	______________________
_____/______/____	____	___________________	______________________
_____/______/____	____	___________________	______________________

SURGICAL HISTORY / SERIOUS ACCIDENTS / HOSPITALIZATIONS: *** If NONE, please check ______**

Date	Operation or Illness	Doctor	Hospital	Complications

FAMILY HISTORY: List any 1st Degree relatives (mother, father, grandparents, siblings, and children) who have had any of the following:

Unknown / Adopted __________________

				Cancers:	
Endometriosis	__________________	Stroke	__________________	Breast	__________________
Uterine fibroids	__________________	Diabetes	__________________	Ovarian	__________________
Heart attack	__________________	Osteoporosis	__________________	Colon	__________________
High blood pressure	__________________			Melanoma	__________________
Blood Clots	__________________	Other	____________________________	Other	____________________

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SOCIAL HISTORY:

School completed: High School ___ 2 YR College ___
4 YR College ___ Grad School ___

Occupation: ___________________________________

Exercise weekly? 0 – 1 ___ 2 – 3 ____ more than 4 ____

Use of alcohol? Never ____ Rarely ____ Moderate ____
Daily_____ Two or more times in the past 12 months had four or more alcoholic beverages in one day? _____

Use of recreational drugs? Never ___ Previous ____ Current ___
Drug used ____
Use of tobacco? Never ___ Previous ____ Current ____
(# per/day ____ # Yrs ___)

Are you currently a victim of domestic violence? Yes ____ No ____
Physical ____ Emotional _____ Sexual _____
Have you ever been a victim of Sexual/Physical/Emotional abuse?
Yes ____ No ____

Please Specify: ___________________________________

MEDICAL HISTORY (Have you been diagnosed with any of the following illnesses? If so note YEAR of diagnosis):

Illness:	Yes	No	Date
GYNECOLOGICAL:			
STD/STI;	( )	( )	__________
***If YES, please circle**: Chlamydia, herpes, genital warts Gonorrhea, syphilis, trichomonas*			
Vaginal Infections:	( )	( )	__________
If YES, please circle: bacterial infection, yeast infection			
Endometriosis	( )	( )	__________
Uterine Fibroids	( )	( )	__________
CARDIOVASCULAR:			
Heart Murmur	( )	( )	__________
Heart Attack	( )	( )	__________
Heart Defect	( )	( )	__________
Heart Palpitations	( )	( )	__________
High Blood Pressure	( )	( )	__________
High Cholesterol	( )	( )	__________
Thrombophlebitis	( )	( )	__________
CONGENITAL:			
Hereditary Defects	( )	( )	__________
DIGESTIVE:			
Diverticulosis	( )	( )	__________
Reflux	( )	( )	__________
Stomach Ulcers	( )	( )	__________
Irritable bowel	( )	( )	__________
ENDOCRINE:			
Diabetes	( )	( )	__________
Thyroid Disease	( )	( )	__________
Anemia	( )	( )	__________
Liver Disease	( )	( )	__________

Illness:	Yes	No	Date
HEMATOLOGICAL:			
Bleeding Tendencies	( )	( )	__________
Blood Clots	( )	( )	__________
MUSCULOSKELETAL:			
Osteoporosis	( )	( )	__________
Osteopenia	( )	( )	__________
NEOPLASM:			
Cancer/Type ___________	( )	( )	__________
NEUROLOGICAL:			
Convulsions / Seizures	( )	( )	__________
Migraines	( )	( )	__________
Stroke	( )	( )	__________
PSYCHIATRY			
Mental Illness	( )	( )	__________
If Yes, Diagnosis: ___________________________			
RESPIRATORY:			
Asthma	( )	( )	__________
Pneumonia	( )	( )	__________
Tuberculosis	( )	( )	__________
Rheumatic Fever	( )	( )	__________
SIGNS/SYMPTOMS:			
Glaucoma	( )	( )	__________
UROLOGY:			
Bladder Leakage	( )	( )	__________
Frequent Bladder Infections	( )	( )	__________
Kidney Infections	( )	( )	__________
Kidney Disease	( )	( )	__________
Kidney Stones	( )	( )	__________
Other: ___________________________________			

Continued on Reverse Side →

NEW PATIENT INFORMATION FORM Room# _________

PATIENT NAME: __________________________ **DOB:** ________/________/_________ **Age** ___________

____ Single ____ Engaged ____ Married _____ Life partner ____ Lesbian ____Separated ____ Divorced _____Widow

GYNECOLOGIC HISTORY:

First day of last menstrual period: _____/_____/_____
#of days from one period to the next? __________
# of days your periods last? _________
Are your Periods:
Light ____ **Cramps with period**: *YES/NO*
Medium ____ **Excessive Bleeding**: *YES/NO*
Heavy _____ **Spotting between cycles**: *YES/NO*

Gender of sexual partners: M _____ and/or F _____
Are you currently sexually active? *YES/NO*
If Menopausal at what age? _________
Have you taken hormone replacement in the past? *YES/NO*
If so how long? _______________

Have you been vaccinated against HPV? *YES/NO*
Number of Injections: 1 ____ 2____3 ____

What are you using to prevent Pregnancy?
___ Birth control pills ___ Condoms ___ IUD ___ Diaphragm ___Vasectomy ___Tubal Ligation___ Withdrawal
Other: ___________________________________

Sexual Orientation: Straight or Heterosexual ____ Bisexual ____ Lesbian, Gay, or Homosexual, ____ Other____
Gender Identity: Female ____ Male ____ Genderqueer, neither male or female exclusively ____
Transgender female/Trans women/Male to female ____ Transgender male/Trans man/Female to male ____

Last Pap smear: ________/________/________ **Results:** ________________________ **History of abnormal?** ***YES/NO***
Colonoscopy: ________/________/________ **Results:** ________________________
Bone Density: ________/________/________ **Results:** ________________________
Mammogram: ________/________/________ **Results:** ________________________ **History of abnormal?** ***YES/NO***
Date of last flu shot: ______/______/________
If age 65, date of Pneumonia Vaccine: _____/_______/_________

Family History of Breast Cancer: ***YES/NO*** **Whom:** ____

MEDICATIONS (List all current medications that you are taking, including vitamins and herbal supplements):

DRUG	DOSAGE	FREQUENCY TAKEN

Office use only*

Vital Signs: **HT** ________ **WT** ________ **BP** ________/_________

G________ **P**________

LMP ______________ **BMI**:_________

S/A _____________________ **Cramps w menses** ______________________

SMOKER: Current / Previous / Never

U/A Reference:
Neg Neg Neg 10001-1.035 Neg 4.6-8.0 Neg Normally present up to 1.0 mg/dl Neg Neg

IFOB: _______
HPV: _______
STD: _______
LDM: ______
ERX: _______
M/O: _______

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