PREMIER CARE FOR WOMEN
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	____________________

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: ____________________			

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

REVIEW OF SYSTEMS:

CONST: Fatigue, body aches, weight loss, weight gain, fever, chills, night sweats	**CARDIO**: Chest pains, rapid or irregular heart beats
EYES: Impaired vision	**RESP**: Shortness of breath, cough
HENT: Headaches	**NEURO**: Muscular weakness, tingling or numbness
BREASTS: Lumps, swelling, tenderness, nipple discharge	**MUSC**: Joint pain, muscle pain
GI: Nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stools, loss of appetite, hemorrhoids	**ENDO**: Heat or cold intolerance, excessive thirst
GU: Urgent or frequent urination, blood in urine, painful intercourse, vaginal discharge, genital sores, incontinence	**PSYCH**: Anxiety, depression, difficulty sleeping
INTEGUMENT: Rash, new or growing moles, excessive hair growth	**HEME/LYMPH**: Easy bruising, easy bleeding

Office use only*

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

LMP ______________ **BMI**:_________

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

SMOKER: Current / Previous / Never

IFOB: _______

HPV: _______

STD: _______

LDM: ______

ERX: _______

M/O: _______