

NEW PATIENT MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Reason for visit: _____

PAST MEDICAL HISTORY: Please check any of the medical conditions below that you have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Head Aches | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Genetic Diseases | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Seizure Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Anemia | <input type="checkbox"/> Other |

Please explain any of the above: _____

SURGERY: Please list date, type of surgery, and hospital for all procedures.

DATE	TYPE OF SURGERY	HOSPITAL

ALLERGIES: Please list the name of any medication you are allergic to and the reaction you had:

MEDICATIONS: Please list all current medications you are taking.

MEDICATION	DOSAGE	HOW OFTEN DO YOU TAKE IT?

GYN HISTORY:

Age of first menstrual period: _____ Have you ever had a sexually transmitted disease: _____
 Length of menstrual flow in days: _____ (Herpes, Gonorrhea, Chlamydia, HIV)
 Amount of flow: Light Moderate Heavy Have you ever used birth control pills: _____
 Do you have regular menstrual periods: _____ Have you ever used an IUD: _____
 Have you ever had an abnormal PAP: _____ Have you ever used Depo Provera: _____
 How was it treated: _____

PREGNANCY HISTORY: Please list all pregnancies including abortions, miscarriages, full term pregnancies, etc.

DATE	FULL TERM PRE TERM MISSCARIAGE ABORTION	WEEKS PREGNANT AT DELIVERY	SEX	VAGINAL OR C-SECTION	COMPLICATIONS

SOCIAL HISTORY:

Do you smoke: _____ How many packs per day: _____ How long have you been smoking: _____
 Do you drink alcohol: _____ What kind of alcohol: _____ How much do you drink: _____
 Have you ever used drugs: _____ Which drugs: _____

FAMILY HISTORY: Do you have any blood relatives with any of the conditions listed below?

_____ Colon Cancer	_____ High Blood Pressure	_____ Thyroid Disease
_____ Uterine Cancer	_____ Heart Attack	_____ Stroke
_____ Cervical Cancer	_____ Lung Disorder	_____ Kidney Disease
_____ Breast Cancer	_____ Endometriosis	_____ Liver Disease
_____ Ovarian Cancer	_____ Mental Disorders	_____ Diabetes
_____ Osteoporosis	_____ Babies with Birth Defects	_____ Blood Disorders
_____ Other: _____		

SYMPTOMS: Please check any that apply

_____ Recent weight loss	_____ Blood in stool	_____ Cold all the time
_____ Recent weight gain	_____ Black colored stools	_____ Hot all the time
_____ Fevers	_____ Abdominal pain	_____ Nervousness
_____ Skin rash	_____ Decreased appetite	_____ Memory loss
_____ Loss of hearing	_____ Burning with urination	_____ Lumps in breast
_____ Severe mood swings	_____ Frequent urination	_____ Depression
_____ Nipple discharge	_____ Blood in urine	_____ Chest pain
_____ Pain with intercourse	_____ Leaking of urine	_____ Painful periods
_____ Swelling of the feet	_____ Varicose veins	_____ Hot flashes
_____ Heartburn	_____ Night sweats	_____ Joint pain
_____ Nausea	_____ Seizures	_____ Vomiting
_____ Irregular vaginal bleeding	_____ Easy bruising	_____ Vaginal itching
_____ Diarrhea	_____ Excessive sweating	_____ Vaginal discharge
_____ Constipation	_____ Excessive thirst	_____ Vaginal dryness