



NEW PATIENT HISTORY

5027 – 10/27/15

Medical History – Page 1

This form is to be completed by the patient

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Last Menstrual Period: _____

Pharmacy (name, address, phone #): _____

Primary Care Physician (name, address, phone#): _____

Allergies: _____

Medications: List all medications you are taking including herbs and vitamins. _____

Family History: If any family members have any of the following – please circle and indicate which relative.

(MOTHER/FATHER, BROTHER/SISTER, AUNT/UNCLE, GRAND MOTHER/FATHER, SON/DAUGHTER), SIDE OF FAMILY (MATERNAL vs. PATERNAL), AND AGE OF DIAGNOSIS

- | | | | | |
|----------------|-------------------|----------------------------|---------------------|---------------|
| Breast Cancer | Ovarian Cancer | Uterine/Endometrial Cancer | High Cholesterol | Heart Disease |
| Colon Cancer | Pancreatic Cancer | Osteoporosis | Bleeding Disorder | |
| Melanoma | Stomach Cancer | Diabetes | High Blood Pressure | |
| Other Cancers: | | | | |

Past Medical History: Circle the items that apply to you now or in the past.

- | | | | | |
|-------------------|----------------------------|-----------------------------|----------------------|-------------|
| Anxiety | Uterine/Endometrial Cancer | Polycystic Ovarian Syndrome | Diabetes | HPV Vaccine |
| Headache/Migraine | Cervical Cancer | Fibroids | Thyroid Disease | HPV |
| Depression | Stomach Cancer | High Blood Pressure | Liver Disease | HIV |
| Melanoma | Pancreatic Cancer | Stroke | Kidney Infection | Chlamydia |
| Breast Cancer | Convulsions/Epilepsy | Heart Murmur | Kidney Stones | Herpes |
| Ovarian Cancer | Asthma | Bleeding Disorder | Blood Clot | Gonorrhea |
| Colorectal Cancer | 10 or more Colon Polyps | | Abnormal pap date(s) | Syphilis |
| Other Cancers: | | | Treatment for pap | _____ |

Any other diagnosis? _____

Are you of Ashkenazi Jewish Descent? Yes No

Past Surgical History: List all surgeries that you have had and the year they were done.

Menstrual History:

Age at onset: _____ Interval between periods: _____ days

Average days of menstrual flow: _____

Pain with menstrual periods (circle the severity) Mild Severe

Emotional changes with menstrual periods Mild Severe

Sexual History:

Are you sexually active?	Yes	No	Optional (*Required for Medicare)		
			*Did the onset of your sexual activity occur under 16 yrs. of age?	Yes	No
Are you having any sexual problems?	Yes	No	*Have you had five or more sexual partners?	Yes	No
Do you want to discuss any sexual problems today?	Yes	No	*Have you had a Pap smear within the past 7 years?	Yes	No

Review of History: Initials _____

Review of Systems: Initials _____

Medical History – Page 2

Name: _____

DOB: _____

Date: _____

Pregnancies:			
Year	Vaginal/Cesarean	City	Complications

Social History:
 If you work outside the home, what type of work do you do: _____

Circle the items that apply to you. Marital Status: Single Married Divorced Widowed Separated

If married, spouses name: _____

Tobacco use: No Yes Packs per day Drug use: No Yes

Alcohol use: No Yes Drinks per week Exercise: No Yes Type: _____

Review of Systems: (12 Systems) *Circle items that apply to you.*

Constitutional:	Good general health	Yes	No	Breast:	Persistent pain	No	Yes
	Weight loss	No	Yes		Nipple discharge	No	Yes
	Weight gain	No	Yes		Lump or mass	No	Yes
	Fever	No	Yes		Musculoskeletal:	Joint pain	No
Cardiac:	Chest pain or angina	No	Yes	Muscle weakness		No	Yes
	Palpitations	No	Yes	Neurologic:	Seizures	No	Yes
	Swelling in feet/hands	No	Yes		New onset headache	No	Yes
Respiratory:	Chronic cough	No	Yes		Paralysis	No	Yes
	Shortness of breath	No	Yes	Endocrine:	Hair loss	No	Yes
	Wheezing	No	Yes		Acne	No	Yes
Gastrointestinal:	Frequent diarrhea	No	Yes		Hot flashes	No	Yes
	Blood in stool	No	Yes		Heat/cold intolerance	No	Yes
	Chronic constipation	No	Yes	Excessive thirst	No	Yes	
	Nausea or vomiting	No	Yes	Hematology:	Bleed or bruise easily	No	Yes
Urological:	Incontinence or loss of urine with cough or laughter, etc.	No	Yes		Anemia	No	Yes
	Blood in urine	No	Yes	Psychiatric:	Little interest or pleasure in doing things	No	Yes
	Urinary frequency	No	Yes		Feeling down, depressed or sad	No	Yes
	Pain with urination	No	Yes		Feelings of anxiety	No	Yes
Gynecological:	Periods last more than 7 days	No	Yes		Bipolar	No	Yes
	Time between periods is more than 35 days	No	Yes		Other		
	Bleeding between periods	No	Yes				
	Have you had a period in the past 6 months	No	Yes				
	If menopausal: Any bleeding since menopause	No	Yes				
	Severe pain with periods	No	Yes				

Reason for your visit today: _____

Patient Signature: _____ Physician Signature: _____