NEW PATIENT HISTORY FORM

NAME: ____ **BIRTH DATE:** ____________ **AGE:** __________

TODAY'S DATE: ____

WHO REFERRED YOU: ____

REASON FOR YOUR VISIT TODAY: ____

In the past 6 months, have you had any of the following symptoms?
Vaginal bleeding _____ Rectal bleeding ______ Irregular Menses _____ Change in bowel/bladder habits ______
Bloating _______ Leg swelling _____ Urinary incontinence _____ Nausea and vomiting _____ Abdominal pain _____
Fevers _____

Have you had imaging in the past year?
CT Scan ____ MRI ____ Ultrasound ____ PET Scan ____
Date: ______________________________

Please date the last time you had:
Mammogram ____________ Colonoscopy _____________ Pap smear ___________ Menstrual Period ________

Operations (List type and year)**:** ____

Pregnancy History:
Full term _______ Premature _______ Abortion _______ Number of living children ______
Number of Vaginal Deliveries _______ Cesarean ________

Other Medical Conditions:
AIDS (HIV) ____ Headaches____ Alcoholism/chemical dependency ____ Heart problems ____ Alzheimer's ____
Hepatitis ____ Anemia ____ Kidneys problems ____ Arthritis _____ Gout ____ Liver problems ____ Asthma ____
Bleeding Disorder _____ High blood pressure _____ Breast lump _____ Pneumonia ____ Cancer ____
Psychiatric Disorders _____ Herpes ____ Stroke _____ High Cholesterol _____ Thyroid Disorder _____
Diabetes _____ Tuberculosis ____ Emphysema _____ Parkinson Disease _______ Epilepsy _____ Sarcoid _____

MEDICATION LIST (Please include name of medication, dose, and how much often you take the medication.)

Name of Medication	Dose/Strength	How Often Taken

LIST ALL ALLEGIES (Drug, food, etc.)

Allergies	Reaction

Do you take any blood thinners (Coumadin, Aspirin or Lovenox)? ____

____

In the past 3 months, have you had any of the following symptoms?

Fever ____ Paralysis or weakness of limbs ______ Fatigue ________ Dizziness ______ Lack of appetite _______
Numbness ______ Weight gain ______ Weight loss _____ Kidney problems _______ Seizures ______
Heart palpitations _____ Blood in urine ____ Chest pain ______ Pain or burning with urination _____
Shortness of breath _____ Painful Intercourse _____ Back Pain _____ Bleeding between period ______
Joint aches ______ Extreme menstrual pain ______ Change in stool color ______ Hot flashes/night sweats______
Excessive belching ____ Anxiety ______ Indigestion _____ Depression ______ Fainting _____
Difficulty sleeping ____ Vision change _____ Sinusitis ______ Glasses ______ Tinnitus ____ Headache _____
Discharge ____ Rash _____ Mastalgia _____ Hyperthyroid ______

Family History:

	Father	Mother	Sister	Brother	Grandparents
Cancer (What type?)					
Stroke					
Diabetes					
Heart Attack					
High blood pressure					

Have you or anyone in your family had genetic testing? Yes ____ No ______

Have you received HPV vaccine series? Yes____ No ____ If yes, when? __________

What is the name and phone number of your primary care physician? ________________________________

What is the name and phone number of your gynecologist? ____

What is the name and address of your pharmacy? ____

History (Are you?)**:**

Smoking now: Yes _____ No ____ If yes, how much per day? _________

Drinking Alcohol: Yes ____ No ____ If yes, how much per day? _______

Drug Use: Yes _____ No ____ If yes, how much per day? _________ What type of drug? ______________

Marital Status:
Single ______ Married _______ Domestic Partner _________ Divorced Widowed _________

Education: 9 10 11 12 University: _________________ Graduate School: _________________

Occupation:
Yours: ___________________________ Spouse: ____

Religious Preference: ____

Patient Signature: ____ Date: ____________________________

Physician Signature: ____ Date: _________________________________