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OB/GYN NEW PATIENT INFORMATION

Date:________________

Name:____DOB:_________________Age:________

Allergies:____

Current Medications:____

Past Medical History:____

Age at Onset of Menses:___________Days between cycles:______________Duration:________

Last Menstrual Period:_________________Problems with Menses:________________________

Year or Age of Menopause:_____________________HRT:_______________________________

Total # Pregnancies:_________#Vaginal_________#C-Section_______#Full Term Del.________

#Living_______#Premature_________#Miscarried________#Abortion______ #Ectopic________

Pregnancy Complications:____

Self Care Last Pap:_____Location:___________Last Bone Density:_______Location:________
Dates: Last Mammo:_______Location:_________Self Breast Exam: Yes:_____No:________

Past Gyn Procedures (biopsies, etc.)____

Contraception:___________Past Methods:____

Current method (you &/or partner):____

Childhood Illnesses:____

Serious or Chronic Illnesses:
Endocrine (thyroid / diabetes / other):______________________Lungs:______________________
Digestive System:______________________________________Urinary System:______________
Bones / Muscles / Joints:________________________Allergy / Immune System:_____________
Skin:____Gynencological:______________________
Other:____

Surgical History:
Any in-patient or out-patient surgery – with or without anesthesia:__________________________
____

Family Medical History: (ie: cancer, heart disease, diabetes, high blood pressure, thyroid disease, kidney disease)
Mother:___________________________________Father:___________________________________
Maternal Grandmother:____
Maternal Grandfather:____
Paternal Grandmother:____
Paternal Grandfather:____

Social History:
Marital Status:_________Live With:_________Education:_________________________________
Current Employment:____
Diet, Meals / day:___________Rate your diet: Poor_____Fair_____Good____Excellent_______
Pets:________Cigarettes: Past_______Present______Alcohol: Past_____Present___________
Caffeine # / day: Soda:_________Coffee:_______Tea:_________Street Drugs:______________

Sexual History:
Age at first intercourse:_________________________# Partners in Life:____________________
History of sexually transmitted diseases:____