New Patient Obstetrics & Gynecology Form

This will become part of your medical record. Today's Date:

Name: Date of Birth: Age:

Primary Care Physician: Telephone:

Pharmacy: Pharmacy Address:

Menstrual History:

First day of last menstrual period

Age at first menstrual period ____ years

Number of days from the start of one period to the start of the next ____ days

Number of days that you bleed ____ days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day?

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? ____ years

Have you had bleeding or spotting since your periods stopped? Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method:

Birth control methods used in the past:

	METHOD	LENGTH OF USE	REASON FOR DISCONTINUATION
1)			
2)			

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Have you had a new sexual partner in the past three months? Yes ☐ No ☐

How many sexual partners have you had in the past 3 months?

Is/Are your partner(s) male, female, or both? Male ☐ Female ☐ Both ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Would you like to discuss sexual activity or birth control today? Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes ☐ No ☐

Last Pap Smear

Last Mammogram

Last Bone Density (DEXA)

Last Colonoscopy

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

Abnormal Pap Smears Yes ☐ No ☐

Sexually transmitted diseases Yes ☐ No ☐

List:

Fibroids Yes ☐ No ☐

Endometriosis Yes ☐ No ☐

Infertility Yes ☐ No ☐

Urinary incontinence Yes ☐ No ☐

Obstetrical History: Please record the number of:

Pregnancies ☐ Vaginal Births ☐ Ectopics ☐ Abortions ☐
Living Children ☐ C-Sections ☐ Miscarriages ☐

List any complications of pregnancies ☐

Medical History: Please check if you or a blood-relative have had any of the following:

	MYSELF	FAMILY		MYSELF	FAMILY		MYSELF	FAMILY
Anemia	☐	☐	Mental Illness	☐	☐	Liver Disease / Hepatitis	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Gall Bladder Disease	☐	☐
High Cholesterol	☐	☐	Anxiety	☐	☐	Blood clots in veins/lungs	☐	☐
Heart Disease	☐	☐	Eating disorder	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Migraine Headaches	☐	☐	Breast Cancer	☐	☐
Diabetes	☐	☐	Urinary Tract Infection	☐	☐	Colon Cancer	☐	☐
COPD / Emphysema	☐	☐	Lupus	☐	☐	Uterine Cancer	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Ovarian Cancer	☐	☐
Seizures	☐	☐	Back Injury	☐	☐	Other Cancer, specify:		
Thyroid problems	☐	☐	Osteoporosis	☐	☐			

Other Medical Problems (list all):

Surgical History: Please list any operations, including the year, or your age when you had it:

Personal / Social History:

Occupation ☐ Marital Status ☐

Do / Did you use tobacco products? Yes ☐ No ☐ How much? ☐
Do / Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? ☐
Do / Did you use illicit/street drugs? Yes ☐ No ☐ Which drugs? ☐
Have you ever been tested for HIV? Yes ☐ No ☐ Year and result: ☐
Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes ☐ No ☐

Medications: Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications: ☐

Current Medical Concerns: Please circle if you have had any of the following this week: ☐

Weight change	Yes ☐ No ☐	Nausea / Vomiting	Yes ☐ No ☐	Trouble sleeping	Yes ☐ No ☐
Abnormal bleeding	Yes ☐ No ☐	Bowel changes	Yes ☐ No ☐	Night sweats / Hot flashes	Yes ☐ No ☐
Abnormal hair growth	Yes ☐ No ☐	Anxiety / Panic	Yes ☐ No ☐	Breast problems	Yes ☐ No ☐
Problems with urination	Yes ☐ No ☐	Depression	Yes ☐ No ☐		

How did you hear about us? ☐

Is there any other information you feel we should have?

Patient Signature _____ Date _____ Provider Signature _____ Date _____

Personal & Family Cancer History

Name: _____ Date: _____ Date of Birth: _____ Age: ____

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides.** Specify which relatives were affected and estimate ages of diagnosis to the best of your ability. This is a screening tool for the common features of hereditary cancer syndromes. Based on the family histor information you provide here, you MAY be appropriate for genetic testing.

1st Degree Relatives: **Parents, Siblings, Children**

2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

CANCER HISTORY			You	Which Relative(s)	Mother's Side	Father's Side	Age of Diagnosis
Yes	No	BREAST CANCER diagnosed age 49 or younger					
Yes	No	PERSONAL history of BREAST CANCER (any age)					
Yes	No	MALE BREAST CANCER (any age)					
Yes	No	OVARIAN CANCER (any age)					
Yes	No	PANCREATIC CANCER (any age)					
Yes	No	3 or more BREAST, PROSTATE, and/or PANCREATIC CANCERS on one family side, any ages					
Yes	No	COLON or UTERINE CANCER age 49 or younger					
Yes	No	3 or more COLON or UTERINE CANCERS on a family side, any ages					

Patient Signature _____

OFFICE USE ONLY

Patient offered genetic testing: Yes / No

Accepted / Declined

Provider Initials: _____