Print Form

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 _____