NEW PATIENT EXAM **Email:_____**

Please fill in completely if you are new to our practice, otherwise just update each category on both sides.

Patient's Name: _____Today's Date: _____
Address_____Date of Birth: _____
Primary Care Physician: _____Phone #_____
Special concerns you wish to discuss today: _____
Allergies/Reactions (include metals, latex, etc.)_____
Medical History: Please list major medical problems, illnesses or injuries_____
_____
Medications: _____
Pharmacy:

Hospitalizations/Surgeries: _____

_____

Gynecologic History				
Is this your 1st pelvic exam	**Yes**	**No**	Date of last Pap:	
How often do you get menstrual periods? Every _____ days.			Last Menstrual Period: Average days bleeding:	
Age when period began:			Concerns with your menstruation?	**Yes** **No**
Did your mother take Hormones to prevent miscarriages?	**Yes**	**No**	Contraception or birth control?	**Yes** **No**

Do you have or have you had:	**Yes**	**No**		**Yes**	**No**
Frequent Vaginal infections			Pain/bleeding with intercourse		
STD-Gonorrhea, chlamydia, herpes, warts			Been sexually abused		
Unusual vaginal discharge/odor			Unusual/missed periods		
Vaginal itching/burning/sores			Severe menstrual cramps		
PID/Infection of uterus, tubes, ovaries			Premenstrual discomfort/PMS		
An abnormal PAP smear			Other		

Obstetrical History			
Number of Pregnancies		Number of Miscarriages	Vaginal or C-Section Delivery
Number of Living Children		Have you ever had an Tubal Pregnancy?	Yes No
Number of Abortions		Did you have any complications with pregnancy?	Yes No
Family History **Mother** **Father**	**Alive**	**Deceased**	**Cause**

Social History	**Yes**	**NO**		**Personal Profile**
Tobacco Use Have you ever smoked?			Packs per day:	Martial Status
Alcohol Use			Drinks per week:	Married Since
Drug Use				Previous Martial status
Caffeine Intake			Per Day:	Children
Domestic Violence				Grandchildren
Regular Exercise			How long?	Occupation
Supplements				Residence (own home, condo, apt)
				Hobbies

Personal HX:	Yes	No	Family HX:	Yes	No	Family Member
Depression			Depression			
Hypertension			Hypertension			
Respiratory Disease			Respiratory Disease			
Kidney Disease			Kidney Disease			
Anemia			Anemia			
Thyroid Disease			Thyroid Disease			
Birth Defects			Birth Defects			
Lung Cancer			Lung Cancer			
Skin Cancer			Skin Cancer			
Colorectal Cancer			Colorectal Cancer			
Stomach Cancer			Stomach Cancer			
Liver Cancer			Liver Cancer			
Breast Cancer			Breast Cancer			
Other Cancer			Other Cancer			
Diabetes			Diabetes			
Heart Disease			Heart Disease			
Asthma			Asthma			
Osteoporosis			Osteoporosis			
Bleeding Disease			Bleeding Disease			
Development Disorders			Development Disorders			
GI Disorder			GI Disorder			

General	Yes	No		Gastrointestinal	Yes	No
Sweats				Nausea		
Anorexia				Vomiting		
Fatigue				Diarrhea		
Weight Loss				Changes in bowel habits		
Insomnia				Abdominal Pain		

Respiratory	Yes	No		Cardiovascular	Yes	No
Cough				Chest Pains		
Difficulty Breathing				Palpitations		
Wheezing				Shortness of breath		

Skin	Yes	No		Breast	Yes	No
Bruising				Pain		
Rash				Lump		
Suspicious lesions				Discharge		
				Skin changes		

GYN	Yes	No			Yes	No
Spotting between periods				Pain with intercourse		
Vaginal discharge				Unusual pelvic pain		

Date of last Mammogram	Date last Bone Density	Date last Colonoscopy

Office Use Only

Vitals	Weight	Height	Blood Pressure	Pulse	Temp

Staff Comments: _____