NEW PATIENT INFORMATION FORM

NAME _____ **DOB** _____ **AGE** _____ **DATE** _____

Race: African American/Black_____, American Indian/Alaskan Native _____, Asian _____, Caucasian/White _____, Pacific Islander/Native Hawaiian _____, Other _____, Declined _____
Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____

Reason for today's visit: _____

Local Pharmacy Name: _____ **Pharmacy phone:** _____

Mail Order Pharmacy: _____ **Phone**: _____

ALLERGIES:
Drug: _____ **Food**: _____
Latex Allergy: Yes _____ No _____

Physician who referred you: _____

Primary Care Provider: _____ Phone: _____

Address: _____ Fax: _____

Other Care providers: (please specify specialty) _____

OBSTETRICAL HISTORY: (Please list all past pregnancies and their outcomes) ***NEVER been pregnant, please check _____**

Date of Delivery (MDY)	Type (Vaginal, C-section, miscarriage, abortion)	Baby Weight/Sex	Complications
_____/_____/____	_____	_____	_____
_____/_____/____	_____	_____	_____
_____/_____/____	_____	_____	_____

SURGICAL HISTORY / SERIOUS ACCIDENTS / HOSPITALIZATIONS: *** If NONE, please check _____**

Date	Operation or Illness	Doctor	Hospital	Complications

FAMILY HISTORY: List of any 1st Degree relatives (mother, father, grandparents, siblings, and children) who have had any of the following:

- ☐ Unknown
- ☐ Adopted

				Cancers:	
Endometriosis	_____	Stroke	_____	Breast	_____
Uterine fibroids	_____	Diabetes	_____	Ovarian	_____
Heart attack	_____	Osteoporosis	_____	Colon	_____
High blood pressure	_____			Melanoma	_____
Blood Clots	_____	Other	_____	Uterine	_____

Continued on Reverse Side →

SOCIAL HISTORY:

School completed: High School ___ 2 YR College ___
4 YR College ___ Grad School ___

Occupation: _____

Exercise weekly? 0 – 1x ___ 2 – 3x ____ more than 4x ____

Use of alcohol? Never ____ Rarely ____ Moderate ____
Daily_____

Use of recreational drugs? Never ___ Previous ____ Current ___
Drug used _____
Use of tobacco? Never ___ Previous ____ Current ____
(# per/day ____ # Yrs ___)
Vaping: Yes_____ No_____

Are you currently a victim of domestic violence? Yes ____ No ____
Physical ____ Emotional _____ Sexual _____
Have you ever been a victim of Sexual/Assault abuse? Yes ___ No _

MEDICAL HISTORY (Have you been diagnosed with any of the following illnesses? If so note YEAR of diagnosis):

Illness:	Yes	No	Date
GYNECOLOGICAL:			
STD/STI;	( )	( )	_____
***If YES, please circle**: Chlamydia, herpes, genital warts Gonorrhea, syphilis, trichomonas*			
Vaginal Infections:	( )	( )	_____
If YES, please circle bacterial infection, yeast infection			
Endometriosis	( )	( )	_____
Uterine Fibroids	( )	( )	_____
Abnormal pap smear (requiring treatment)	( )	( )	_____
Ovarian cyst requiring treatment	( )	( )	_____
CARDIOVASCULAR:			
Heart Murmur	( )	( )	_____
Heart Attack	( )	( )	_____
Heart Defect	( )	( )	_____
Heart Palpitations	( )	( )	_____
High Blood Pressure	( )	( )	_____
High Cholesterol	( )	( )	_____
DIGESTIVE:			
Diverticulosis	( )	( )	_____
Reflux	( )	( )	_____
Stomach Ulcers	( )	( )	_____
Irritable bowel	( )	( )	_____
Colitis	( )	( )	_____
ENDOCRINE:			
Diabetes	( )	( )	_____
Thyroid Disease	( )	( )	_____
Liver Disease	( )	( )	_____

Illness:	Yes	No	Date
HEMATOLOGICAL:			
Bleeding Disorder	( )	( )	_____
Blood Clots (DVT or PE)	( )	( )	_____
Anemia	( )	( )	_____
MUSCULOSKELETAL:			
Osteoporosis	( )	( )	_____
Osteopenia	( )	( )	_____
CANCER:			
Type _____	( )	( )	_____
NEUROLOGICAL:			
Convulsions / Seizures	( )	( )	_____
Migraines	( )	( )	_____
Stroke	( )	( )	_____
OPTHALMIC:			
Glaucoma	( )	( )	_____
PSYCHIATRY			
Depression	( )	( )	_____
Anxiety	( )	( )	_____
Bipolar	( )	( )	_____
RESPIRATORY:			
Asthma	( )	( )	_____
Pneumonia	( )	( )	_____
UROLOGY:			
Bladder Leakage	( )	( )	_____
Frequent Bladder Infections	( )	( )	_____
Kidney Infections	( )	( )	_____
Kidney Disease	( )	( )	_____
Kidney Stones	( )	( )	_____
Bladder pain/interstitial cystitis	( )	( )	

Continued on Reverse Side →

NEW PATIENT INFORMATION FORM **Room# _____**

PATIENT NAME: _____ DOB: _____/_____/_____ Age _____

____ Single ____ Engaged ____ Married _____ Life partner ____Separated ____ Divorced _____Widow

GYNECOLOGIC HISTORY:

First day of last menstrual period: _____/_____/_____
#of days from one period to the next? _____
# of days your periods last? _____
Are your Periods:
Light ____ **Cramps with period**: *YES/NO*
Medium ____ **Excessive Bleeding**: *YES/NO*
Heavy _____ **Spotting between cycles**: *YES/NO*

Gender of sexual partners: M _____ and/or F _____
Are you currently sexually active? *YES/NO*
If Menopausal at what age? _____
Have you taken hormone replacement in the past? *YES/NO*
If so how long? _____

Have you been vaccinated against HPV? *YES/NO*
Number of Injections: 1 ____ 2____3 ____

What are you using to prevent Pregnancy?
___ Birth control pills ___ Condoms ___ IUD ___Vasectomy ___Tubal Ligation
____Abstinence____Menopause_____Same Sex Partner_____Nexplanon

Sexual Orientation: Straight or Heterosexual ____ Bisexual ____ Lesbian, Gay, or Homosexual, ____ Other____
Gender Identity: Female ____ Male ____ Genderqueer, neither male or female exclusively ____
Transgender female/Trans women/Male to female ____ Transgender male/Trans man/Female to male ____

Last Pap smear: _____/_____/_____ **Results: _____**
Colonoscopy: _____/_____/_____ **Results: _____**
Bone Density: _____/_____/_____ **Results: _____**
Mammogram: _____/_____/_____ **Results: _____**
Date of last flu shot: _____/_____/_____
If age 65, date of Pneumonia Vaccine: _____/_____/_____

Family History of Breast Cancer: *YES/NO* **Whom: _____**

MEDICATIONS (List all current medications that you are taking, including vitamins and herbal supplements):

_____

_____

_____

Office use only*

Vital Signs: **HT** _____ **WT** _____ **BP** _____/_____

G_____ **P**_____

LMP _____ **BMI**:_____

SMOKER: Current / Previous / Never | **VAPING:** Yes or No

IFOB: _____

STD: _____

Continued on Reverse Side →