

WOMEN'S NEW PATIENT HISTORY FORM:

Please fill this form to the best of your ability. The doctor will review your answers during the visit.

Your name: _____

DOB: _____

Today's Date: _____

Address: _____

Main Reason for visit: _____

2nd and 3rd top health concerns: _____

Referring source: _____

PAST Medical Problems & treatments/PAST Surgeries (any hospitalizations):

1. _____

2. _____

3. _____

4. _____

5. _____

CURRENT Medical Problems and treatments:

1. _____

2. _____

3. _____

4. _____

5. _____

Date of last TB shot? _____

Date of last cholesterol screen ? _____ RESULT _____

Date of last Diabetes screen? _____ RESULT _____

Date of last colonoscopy? _____ RESULT _____

DOCTOR'S NOTES

Dr. Signature:

SOCIAL HISTORY:

Occupation and hours: _____ Stress Level 0 to 10 _____

Hours of sleep per night: _____

Please circle:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of alcohol:	Never	Occasionally	3-4 x /week	Daily	
Use of tobacco:	Never	Quit date: _____		Current, packs/day_____	
Aerobic Exercise:	None	1-2X/week	3-4X/week	Daily	
Strength training:	None	1-2X/week	3-4X/week	Daily	
Meals/snacks/ day:	2	3-4 X/day	5-6X/day		
Vegetable intake:	<10%	20-40%	41-60%	>61%	

HOBBIES AND INTERESTS:

FAMILY HISTORY (*Please include CANCER, STROKE, HIGH BLOOD PRESSURE, HEART ATTACKS, DIABETES, ALZHEIMER's, OSTEOPOROSIS, THYROID*):

<i>AGE</i>	<i>DISEASES</i>	<i>If deceased: cause/age of death</i>
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MOTHER _____

Maternal GM _____

Maternal GF _____

FATHER _____

Paternal GM _____

Paternal GF _____

AUNTS/UNCLES _____

SIBLINGS _____

CHILDREN _____

NAME: _____

DATE: _____

WOMEN'S OB/GYN HISTORY

Date of Last Menstrual Period: _____

Are your periods regular? _____ Heavy? _____ Length of cycle _____

Total # Pregnancies _____ Living children _____ # vaginal _____ #c/s _____

Are you sexually active? _____ # times per week _____ Problems: _____

Circle if you are heterosexual, bisexual or homosexual

Current method of birth control: _____ Methods used in past: _____

Are you in an abusive relationship? _____ Have you been sexually abused ? _____

Date of last PAP smear: _____ Past abnormalities: _____

Date of last Mammogram: _____ Past abnormalities: _____

Date of last bone density screening: _____ Past abnormalities: _____

Please check all that apply

	NONE	MILD	MODERATE	SEVERE
Sleep disorder				
Anxiety/nervousness				
Irritability				
Depression/mood swings				
Food cravings				
Hot flashes				
Night sweats				
Vaginal dryness				
Urine leakage				
Dry skin/wrinkles				
Dry hair				
Fatigue				
Memory loss				
Concentration loss				
Hair loss				
Loss of libido/orgasm				
Muscle weakness/loss				
Muscle & joint pain				
Loss of pubic hair				

NAME: _____

DATE: _____

REVIEW OF SYSTEMS		
Instructions: Please check YES to any symptom that you experience. For any YES answer, please provide description.		
	YES	If YES, list doctor seen, describe condition and how long.
General		
Have you seen an internist?		
Fever/chills		
Headache		
Dizziness		
Excess fatigue		
Insomnia		
Weight loss/gain		
Enlarged lymph nodes		
Frequent bruising		
Eyes/Ears/Nose/Mouth		
Have you seen ear/nose/throat doc?		
Blurry vision		
ringing in the ears		
Difficulty with vision		
Difficulty with hearing		
Mouth sores		
Sinus problems		
Snoring		
Cardiovascular		
Have you seen a cardiologist?		
Chest pain at rest or exercise		
Shortness of breath		
Cold hands/cold feet		
Swelling of legs		
Palpitations		
Gastrointestinal		
Have you seen a gastroenterologist?		
Constipation		# bowel movement/day ____
Diarrhea		
Bloating		
Excessive belching		
Gas/acidity		
Blood in stool		
Thirst: Lack of/too much		# glasses of fluid/day ____

NAME: _____

DATE: _____

REVIEW OF SYSTEMS		
Instructions: Please check YES to any symptom that you experience. For any YES answer, please provide description.		
	YES	If YES, list doctor seen, describe condition and how long.
Genitourinary		
Have you seen an urologist?		
Pain on urination		
Cloudy/bloody urination		
Urinating too many times		
Difficulty urinating		
Loss of urine		
Night time urination		If YES, # times/night _____
Musculoskeletal		
Do you see a chiropractor?		
Do you get body treatment/massage?		If YES, how frequent? _____
Back pain		
Neck pain		
Shoulder pain		
Knee pain		
Joint pain		
Skin		
Have you seen a skin care specialist		
Acne		
Dry Skin		
Oily skin		
Loss of collagen/firmness		
Wrinkles		
Pigmentation/Scarring		
Hair loss		
Emotional		
Do you see a counselor?		
Depression		
Anxiety		
Stress		

I have answered the above accurately to the best of my knowledge.

Signature: _____