Patient Name_____

Date of Birth_____

Today's Date_____

New Patient Personal and Family History Form

What is your reason for visiting the office today?_____

MEDICATION

Do you have any allergies to medications? ❑ Yes ❑ No
If yes, please list:_____

Do you take medications regularly? ❑ Yes ❑ No If so, please list below (use back if needed)

MEDICATION	DOSE/FREQUENCY/ROUTE	NOTES

PAST MEDICAL HISTORY *Do you now or have you ever had:*

❑ Asthma	❑ Blood clot (DVT or PE)	❑ Cancer (provide details)
❑ Diabetes	❑ Anemia	
❑ High Blood Pressure	❑ Substance Abuse/Addiction	❑ Other Health Problems
❑ High Cholesterol	❑ Stroke	
❑ Hypothyroidism	❑ Epilepsy (Seizures)	
❑ Depression or Anxiety	❑ Kidney Disease	
❑ Heart problems	❑ Ulcer	
❑ Crohn's or Ulcerative Colitis	❑ Hepatitis	
❑ Diverticulitis	❑ HIV/AIDS	

HEALTH SCREENING *When was the date of your last….*

Colonoscopy	Bone Density	Cholesterol Check
Mammogram	Dermatology visit	Dental visit

SURGICAL HISTORY

Have you had any surgeries? ❑ Yes ❑ No If so, please list below with any details:

DATE	SURGERY TYPE	NOTES (COMPLICATIONS?)

Other than surgeries, have you been hospitalized? If so, when and why?

Patient Name:_____ Date of Birth:_____

FAMILY HISTORY *Please check boxes that apply, fill in details, and use spaces to add family members*

	Age	High Blood Pressure	Diabetes	Heart Disease	Obesity	Stroke	Mental Health Issues	Cancer (type, age at diagnosis)	Anesthesia Problems	Thyroid disorder	Other	
Father												
Mother												
Paternal Grandfather												
Paternal Grandmother												
Maternal Grandfather												
Maternal Grandmother												
sibling												

PERSONAL AND SOCIAL HISTORY

What is your highest education? ❑High school ❑College graduate ❑Advanced degree

What do you do for work?_____

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered

Do you smoke? ❑ Yes ❑ No If yes how much?_____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much?_____

Do you use any other drugs, such as marijuana, cocaine or narcotics? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

Do you wear your seatbelt? ❑ Yes ❑ No

Do you have concerns for your safety? ❑ Yes ❑ No

REPRODUCTIVE HISTORY

Have you had any pregnancies? ❑ Yes ❑ No If so, please list below with any details:

DATE	OUTCOME (BIRTH, ABORTION, MISCARRIAGE)	NOTES (D&C, CESAREAN, WEIGHT)

Patient Name:_____ Date of Birth:_____

GYNECOLOGIC HISTORY

Age of first period_____ Date of last period_____Are you periods regular? ❑ Yes ❑ No

How often do your periods come?_____ and how long do they last?_____

Do you have problems with heavy periods? ❑ Yes ❑ No explain_____

Do you have problems with severe cramping? ❑ Yes ❑ No explain_____

Are you sexually active? ❑ Yes ❑ No Are your partner(s) men, women or both?_____

Do you have pain with intercourse? ❑ Yes ❑ No

Have you used birth control? ❑ Yes ❑ No If so, what forms?_____

Have you reached menopause? ❑ Yes ❑ No If so, at what age?_____ Did you take hormones?

When was your last pap smear?_____

Did you get the HPV vaccine (Gardasil)? ❑ Yes ❑ No

Have you ever had an abnormal pap smear? ❑ Yes ❑ No explain_____

Have you ever had genital herpes, chlamydia, syphilis, gonorrhea, or another sexually transmitted infection?_____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Unintentional weight change
- ❑ Fatigue
- ❑ Fever/chills

NEUROLOGIC
- ❑ New/worsening headache
- ❑ Dizziness
- ❑ Memory loss

MUSCLES/JOINTS
- ❑ Joint pain: site_____
- ❑ weakness
- ❑ swelling of joints: site _____

SKIN
- ❑ rash/redness
- ❑ new lesion
- ❑ New/problematic acne

DIGESTIVE
- ❑ Nausea/vomiting
- ❑ abdominal pain
- ❑ constipation
- ❑ Diarrhea
- ❑ Blood in stool

GENITOURINARY
- ❑ Pain with urination
- ❑ Incontinence
- ❑ Blood in urine
- ❑ Frequent urge to urinate

GYNECOLOGIC
- ❑ vaginal discharge/itching
- ❑ pelvic pain
- ❑ abnormal bleeding
- ❑ heavy bleeding
- ❑ pain with intercourse
- ❑ decrease interest in sex

PSYCHOLOGICAL
- ❑ Difficulty sleeping
- ❑ Excessive worries
- ❑ Lack of interest in activity

HEART/LUNGS
- ❑ Chest pain
- ❑ shortness of breath
- ❑ palpitations
- ❑ wheezing

HEAD/NECK
- ❑ hearing difficulty
- ❑ vision problems
- ❑ hoarse voice
- ❑ difficulty swallowing