

NEW PATIENT MEDICAL HISTORY

Patient's Full Name _____

Reason for visit: _____

Are you currently employed? Yes___ No___ Retired___ Martial Status: _____

If yes, what is your current occupation? _____ Company name: _____

Referring Physician: _____

Office Phone: _____ Fax: _____

Primary Care Physician: _____

Office Phone: _____ Fax: _____

Medications

Please list all current medications. Please include dosage (mg) and frequency (once, twice per day, etc)

Medication:	Dosage (mg):	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had an allergic reaction to any medications? Yes___ No___

Do you have a Latex allergy? Yes___ No___

Please list all allergies and reactions to any medications.

Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Tobacco use: Never__ Now__ Past__ How much per day? _____ # of years? _____

When did you quit? _____

Recreational Drug Use? Never__ Now__ Past__ How much per day? _____ # of years? _____

Drug(s) used? _____ When did you quit? _____

Alcohol Consumption? Never__ Now__ Past__ How much per day? _____

of years? _____ When did you quit? _____

Personal Medical History

Please check all illnesses or conditions which you have now or in the past:

- Asthma
- Diabetes
- Glaucoma
- Hepatitis A, B or C
- High Blood Pressure
- Pneumonia

- Tuberculosis
- Thyroid problems, Type_____
- Heart Murmur
- Heart Trouble, Type_____
- Depression/Anxiety
- Bleeding Tendencies
- Cancer, Type_____
- HIV
- Jaundice
- Arthritis/Gout
- Elevated Cholesterol
- Blood Clots
- Sleep Apnea
- Kidney Disease
- Stroke/TIA
- Nervous Disorder
- Obesity
- Mental Illness
- Reflux, Peptic Ulcer
- Difficultly Breathing

Please list all surgeries

Surgery:	Year:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please check illnesses that have occurred in any of your blood relatives and indicate which relative:

- Stroke Relative(s):_____
- High Blood Pressure Relative(s):_____
- Heart Disease Relative(s):_____
- Bleeding Tendencies Relative(s):_____
- Cancer Relative(s):_____
- Diabetes Relative(s):_____
- Mental Illness Relative(s):_____
- Alcoholism Relative(s):_____

Review of Symptoms

Do you now have or ever had the following:

- | | | |
|---|--------|--------|
| Significant weight change | Yes__ | No__ |
| Increase/Decrease by how many pounds | +lbs__ | -lbs__ |
| Any eye disease, injury, impaired sight | Yes__ | No__ |
| Any trouble with nose, sinuses, mouth, and throat | Yes__ | No__ |
| Trouble swallowing | Yes__ | No__ |
| Convulsions | Yes__ | No__ |
| Pain radiating down arm | Yes__ | No__ |
| Shortness of breath | Yes__ | No__ |
| Bleeding gums | Yes__ | No__ |
| Burning pain during urination | Yes__ | No__ |
| Loss of bladder control | Yes__ | No__ |
| Chest pain or tightness in the chest | Yes__ | No__ |
| Blood in urine | Yes__ | No__ |
| Frequent Urination | Yes__ | No__ |
| Coughing up blood | Yes__ | No__ |

Night Sweats	Yes__	No__
Palpitations	Yes__	No__
Painful intercourse	Yes__	No__
Swelling of hands or feet	Yes__	No__
Breast lumps	Yes__	No__
Weakness in arm or leg	Yes__	No__
Frequent or severe headaches	Yes__	No__
Varicose veins	Yes__	No__
Paralysis	Yes__	No__
Enlarged glands	Yes__	No__
Enlarged thyroid or goiter	Yes__	No__
Constipation or diarrhea	Yes__	No__
Hemorrhoids or rectal bleeding	Yes__	No__
Stomach trouble or ulcer	Yes__	No__
Pain in joints or gout	Yes__	No__
Skin irritation or rashes	Yes__	No__
Fainting spells	Yes__	No__
Loss of consciousness	Yes__	No__
Depression or anxiety	Yes__	No__
Spells of dizziness	Yes__	No__
Hallucinations	Yes__	No__

GYN History

Date of last PAP: _____	Normal__	Abnormal__
Last menstrual period: _____	Normal__	Abnormal__
Date of last Mammogram: _____	Normal__	Abnormal__
Number of pregnancies: _____		
Number of miscarriages/abortions: _____		
Number of pre-term births: _____		
Birth control method: _____		
Hormone replacement therapy: _____		
Periods are: Regular Irregular	Painful	Cramps
History of sexually transmitted infection (STD):	Yes__	No__
Have you had a hysterectomy?	Yes__	No__
If so, was it: Abdominal or Vaginal?		
If so, is your cervix still intact?	Yes__	No__
If so, do you still have your ovaries?	Yes__	No__

Urogynecology History

Are you currently experiencing any of the following?

Pelvic prolapse	(Bulging in the vaginal area)	Yes__	No__
Urinary incontinence	(Loss of urine)	Yes__	No__
Anal incontinence	(Loss of stool)	Yes__	No__
Constipation		Yes__	No__