NEW PATIENT HISTORY

5027 – 11/06/20

Medical History – Page 1 ***This form is to be completed by the patient***

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Last Menstrual Period: _____

Pharmacy (name, address, phone #): _____

Primary Care Physician (name, address, phone#): _____

Allergies:

Medications: *List all medications you are taking including herbs and vitamins.*

Family History: *If any **family members** have any of the following – please circle and indicate which relative.*

(MOTHER/FATHER, BROTHER/SISTER, AUNT/UNCLE, GRAND MOTHER/FATHER, SON/DAUGHTER), SIDE OF FAMILY (MATERNAL vs. PATERNAL), AND AGE OF DIAGNOSIS

Breast Cancer	Ovarian Cancer	Uterine/Endometrial Cancer	High Cholesterol	Heart Disease
Colon Cancer	Pancreatic Cancer	Osteoporosis	Bleeding Disorder	
Melanoma	Stomach Cancer	Diabetes	High Blood Pressure	
Other Cancers:				

Past Medical History: *Circle the items that apply to **you** now or in the past.*

Anxiety	Uterine/Endometrial Cancer	Polycystic Ovarian Syndrome	Diabetes	HPV Vaccine
Headache/Migraine	Cervical Cancer	Fibroids	Thyroid Disease	HPV
Depression	Stomach Cancer	High Blood Pressure	Liver Disease	HIV
Melanoma	Pancreatic Cancer	Stroke	Kidney Infection	Chlamydia
Breast Cancer	Convulsions/Epilepsy	Heart Murmur	Kidney Stones	Herpes
Ovarian Cancer	Asthma	Bleeding Disorder	Blood Clot	Gonorrhea
Colorectal Cancer	10 or more Colon Polyps		Abnormal pap date(s)	Syphilis
Other Cancers:			Treatment for pap	_____

Any other diagnosis?

Are you of Ashkenazi Jewish Descent? ☐ Yes ☐ No

Past Surgical History: *List all surgeries that you have had and the year they were done.*

Menstrual History:

Age at onset: _____ Interval between periods: _____ days_____

Average days of menstrual flow: _____

Pain with menstrual periods (circle the severity) Mild Severe

Emotional changes with menstrual periods Mild Severe

Sexual History:			Optional (*Required for Medicare)		
Are you sexually active?	Yes	No	*Did the onset of your sexual activity occur under 16 yrs. of age?	Yes	No
Are you having any sexual problems?	Yes	No	*Have you had five or more sexual partners?	Yes	No
Do you want to discuss any sexual problems today?	Yes	No	*Have you had a Pap smear within the past 7 years?	Yes	No

Review of History: Initials _____ **Review of Systems: Initials** _____

Medical History – Page 2

Name: _____ DOB: _____ Date: _____

Pregnancies:			
Year	Vaginal/Cesarean	City	Complications

Social History:

If you work outside the home, what type of work do you do:

Circle the items that apply to you. Marital Status: Single Married Divorced Widowed Separated

If married, spouses name:

Tobacco use: No Yes Packs per day Drug use: No Yes

Alcohol use: No Yes Drinks per week Exercise: No Yes Type:

Review of Systems: (12 Systems) *Circle items that apply to **you**.*

Constitutional:	Good general health	Yes	No
	Weight loss	No	Yes
	Weight gain	No	Yes
	Fever	No	Yes
Cardiac:	Chest pain or angina	No	Yes
	Palpitations	No	Yes
	Swelling in feet/hands	No	Yes
Respiratory:	Chronic cough	No	Yes
	Shortness of breath	No	Yes
	Wheezing	No	Yes
Gastrointestinal:	Frequent diarrhea	No	Yes
	Blood in stool	No	Yes
	Chronic constipation	No	Yes
	Nausea or vomiting	No	Yes
Urological:	Incontinence or loss of urine with cough or laughter, etc.	No	Yes
	Blood in urine	No	Yes
	Urinary frequency	No	Yes
	Pain with urination	No	Yes
Gynecological:	Periods last more than 7 days	No	Yes
	Time between periods is more than 35 days	No	Yes
	Bleeding between periods	No	Yes
	Have you had a period in the past 6 months	No	Yes
	If menopausal: Any bleeding since menopause	No	Yes
	Severe pain with periods	No	Yes

Breast:	Persistent pain	No	Yes
	Nipple discharge	No	Yes
	Lump or mass	No	Yes
Musculoskeletal:	Joint pain	No	Yes
	Muscle weakness	No	Yes
Neurologic:	Seizures	No	Yes
	New onset headache	No	Yes
	Paralysis	No	Yes
Endocrine:	Hair loss	No	Yes
	Acne	No	Yes
	Hot flashes	No	Yes
	Heat/cold intolerance	No	Yes
	Excessive thirst	No	Yes
Hematology:	Bleed or bruise easily	No	Yes
	Anemia	No	Yes
Psychiatric:	Little interest or pleasure in doing things	No	Yes
	Feeling down, depressed or sad	No	Yes
	Feelings of anxiety	No	Yes
	Bipolar	No	Yes
	Other		

Reason for your visit today: _____

Patient Signature: _____ Physician Signature: _____