# New Patient Health History

Name _____ Age _____ Appointment Date _____
Date of Birth _____ Name of Primary Care Provider _____
Primary reason for the gynecology visit _____

**MEDICATIONS:** Please list all medications that you take (prescription and non-prescription) and dose

| | | |
|---|---|---|
| 1 | 4 | 7 |
| 2 | 5 | 8 |
| 3 | 6 | 9 |

**MEDICAL:** Please mark (X) next to any of the illnesses that you currently have or have had in the past

| Illness | Current | Past | Illness | Current | Past |
|---|---|---|---|---|---|
| High Blood Pressure | | | Autoimmune Disorder | | |
| High Cholesterol | | | Gastric Reflux (GERD) | | |
| Heart Attack | | | Gastric/Duodenal Ulcer | | |
| Stroke | | | Inflammatory Bowel Disease | | |
| Heart Disease | | | Irritable Bowel/IBS | | |
| Mitral Valve Prolapse | | | Hepatitis | | |
| Anemia | | | Liver Disease | | |
| Blood Clot | | | Gallbladder Disease | | |
| Blood Clotting Disorder | | | Kidney Problems | | |
| Bleeding Tendency | | | Seizure Disorder | | |
| Asthma | | | Migraine Headaches | | |
| Lung Disorder | | | Major Depression | | |
| Thyroid Disorder | | | Psychiatric Disorder | | |
| Diabetes | | | Glaucoma | | |
| Adrenal Disorder | | | Blood Transfusion | | |
| Bone Disorder | | | Other Cancer | | |
| Breast Cancer | | | Other: | | |

**ALLERGIES:** Please list all your allergies to medications (including iodine)

| | | |
|---|---|---|
| 1 | 3 | 5 |
| 2 | 4 | 6 |

**OBSTERIC:** Please list all your previous pregnancies (including miscarriages, terminations, stillbirths and ectopics)

| Year | Delivery (vaginal/c-section/ectopic/etc.) | Complication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**SURGICAL:** Please list all your previous surgeries

| Year | Surgery | Complication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**GYNECOLOGIC:**

**Menses:** Age menses began at age _____ First day of last menses _____ Year when menses stopped _____
Menses come every _____ days; last _____ days; with a heavy flow on _____ days
How many days of cramping do you have with your period? _____ [ ] Mild [ ] Moderate [ ] Severe

**Family Planning**: Are you currently trying to conceive? [ ] Yes [ ] No If yes, how long have you been trying?_____
If no, please check what contraception type that you are currently using:
[ ] Pills [ ] Vaginal Ring [ ] Depo-Provera [ ] Nexplanon [ ] Patch [ ] Condoms [ ] Diaphragm
[ ] Withdrawal [ ] Spermicide [ ] Natural Family Planning [ ] Partner is sterile [ ] Menopause
[ ] IUD (type and date of insertion_____) [ ] Tubal ligation [ ] Vasectomy [ ] Hysterectomy

**Gardasil**: Have you had 3 Gardasil vaccines within one calendar year in the past? [ ] Yes [ ] No

**GYN Conditions**: Please check if you have been diagnosed with any of the following:
[ ] Fibroids [ ] Endometriosis [ ] Uterine polyps [ ] Adenomyosis
[ ] Gonorrhea [ ] Chlamydia [ ] Syphilis [ ] Trichomonas [ ] Genital Herpes [ ] HIV

**Pap Smears**: Have you ever had an abnormal pap smear? [ ] Yes [ ] No
If yes, please check all treatments that you have had:
[ ] Repeat pap [ ] Colposcopy/biopsy (Year: _____) [ ] Cryo/freezing (Year: _____)
[ ] LEEP surgery (Year:_____) [ ] Cold Knife Cone surgery (Year: _____)

**Sexual Activity**: Are you currently sexually active? [ ] Yes [ ] No Sexual partners are [ ] Men [ ] Women [ ] Both
Have you ever been raped or sexually abused? [ ] Yes [ ] No

**Breast Issues**: Have you ever had a breast biopsy? [ ] Yes [ ] No If yes, was it normal? [ ] Yes [ ] No

**Urinary Issues**: Are you currently experiencing: [ ] Loss of urine when coughing or straining [ ] Sudden loss of urine
If you checked any of the above, are they a significant problem for you? [ ] Yes [ ]No

**Menopause**: Please check if you currently have any of the following:
[ ] Hot flashes [ ] Night sweats [ ] Mood swings [ ] Trouble Sleeping [ ] Vaginal dryness [ ] Painful intercourse
If you checked any of the above, are they a significant problem for you? [ ] Yes [ ] No

Are you currently using hormones? [ ] Yes [ ] No If yes, how long have you used them? _____
Have you ever taken hormones? [ ] Yes [ ] No If Yes, how long have you used them? _____

Date of last pap smear _____ Was it normal? [ ] Yes [ ] No [ ] Don't know
Date of last mammogram_____ Was it normal? [ ] Yes [ ] No [ ] Don't know
Date of last DEXA bone scan _____ Was it normal? [ ] Yes [ ] No [ ] Don't know
Date of last colonoscopy _____ Was it normal? [ ] Yes [ ] No [ ] Don't know

**FAMILY:** Please indicate the blood relative in your family (**M**other, **F**ather, **B**rother, **S**ister, **A**unt, **U**ncle, **G**randparent) that has been diagnosed with the following illnesses:

| Illness | Relative | Illness | Relative | Illness | Relative |
|---|---|---|---|---|---|
| High blood pressure | | Breast cancer | | Blood clot | |
| High cholesterol | | Ovarian cancer | | Bleeding disorder | |
| Heart attack | | Colon cancer | | Osteoporosis | |
| Stroke | | Uterine cancer | | Other: | |
| Diabetes | | Melanoma | | Other: | |

**SOCIAL:** Occupation_____ Employer_____
Marital Status: [ ] Single [ ] Engaged [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
Do you currently smoke cigarettes? [ ] Yes [ ] No If yes, how many per day? _____ How many years? _____
Have you smoked cigarettes in the past? [ ] Yes [ ] No If yes, when did you quit? _____
In the past year, what is your average consumption alcohol? _____ drinks per day / week / month (please circle)
Do you currently use drugs ? [ ] Yes [ ] No If yes, what do you use? _____
Are you recovering from any addiction to alcohol or drugs in the past? [ ] Yes [ ] No