WOMEN'S HEALTH SPECIALISTSNew Patient Confidential History Date_____

Name:_____ Age:_____ Birthdate:_____

Marital Status: S M Sep Widow Race:_____ Ethnicity:_____

Chief Complaint:_____
Reason for office visit:

GYNECOLOGIC HISTORY

Age when periods started:_____
Last period began:_____ Normal? Yes No
How often do they last?_____
How often do they occur?_____
Are you bothered by : Clots Cramps Mood Changes
Date of Last Pap:_____
Have you had an abnormal Pap? Yes No When?_____
Did your mother take DES when pregnant with you? Yes No
Are you having intercourse? Yes No
Age of first intercourse:_____
Are you using birth control? Yes No
What type of birth control?_____
Problems or pain with intercourse? Yes No
Have you ever had a mammogram? Yes No
Do you do self breast exams? Yes No
Do you have abnormal vaginal discharge? Yes No
Do you have urine leakage? Yes No
Have you ever had a bone density test? Yes No

PREGNANCY HISTORY

Number of vaginal deliveries:_____ Dates:_____
Number of miscarriages:_____ Dates:_____
Number of abortions:_____ Dates:_____
Number of tubal pregnancies_____ Dates:_____
Number of Cesarean Sections_____ Dates:_____
Any complications with pregnancy? Yes No
Any future pregnancy plans? Yes No

Page Two Women's Health Specialists New Pt. Name:_____
MEDICAL HISTORY_____

Present/Past Medical Problems: Please Circle

eye problems	asthma	kidney disease	thyroid disease
ear problems	lung disease	arthritis	cancer type_____
rheumatic fever	gastrointestinal disease	migraines	drug/alcohol abuse
heart murmur	ulcer disease	stroke	childhood illness
heart disease	gallbladder disease	diabetic insulin/no insulin	colonoscopy
hypertension	liver disease/hepatitis	head injury	sigmoidoscopy
high cholesterol	breast disease	psychologic disease	
circulatory problems	gynecologic disease	anemia	
blood clots	bladder infections	blood disease	

Previous Surgery/hospitalizations

1.)_____ 3.)_____

2.)_____ 4.)_____

PRESENT MEDICATIONS:_____

_____

_____

Allergies: Yes No Describe:_____
Do you smoke? Yes No How much?_____ How many years?_____ Occupation:_____
Alcohol Consumption? Yes No Amount per week:_____
Do you use drugs? Yes No Domestic Violence? Yes No
Do you exercise? Yes No Wear seat belts? Yes No
Unusual stress? Yes No Caffeine use? Yes No Amount:_____

REVIEW OF SYSTEMS Please CIRCLE any new problems since the last visit:

weight loss/gain	recurrent diarrhea	excessive weakness	urine urgency
recurrent fever	constipation	swelling of hands/feet	swollen glands
excessive fatigue	change of bowels	varicose veins	easy bruising
changes in vision/hearing	nausea/vomiting	pain in joints	new allergies
excessive headaches	heartburn	pain/mass in breast	last tetanus shot:
sinus infections	blood in stool	discharge from breast	_____
dental problems	pain in abdomen/pelvis	skin or mole changes/sores	immunizations:
mouth ulcers	abnormal bleeding from vagina	numbness/tingling	_____
dry mouth	change in menstrual period	lightheadedness	
chest pain	hot flashes	anxiety	
heart palpitations	vaginal/rectal itching	depression	urine frequency
shortness of breath	abnormal discharge from vagina	insomnia	chronic cough
sexually active yes/no	excessive thirst	hoarseness	
difficulty with intercourse	urine loss	difficulty swallowing	
new bone fracture			

FAMILY HISTORY (age and health)

Mother:_____
Father:_____
Siblings:_____

Have any of your BLOOD RELATIVES ever had or have:

Diabetes	yes	no	_____
Heart Disease	yes	no	_____
Birth defects and inherited disorders	yes	no	_____
Tuberculosis	yes	no	_____
High blood pressure	yes	no	_____
Clot/bleeding problems	yes	no	_____
Cancer:(site)_____	yes	no	_____
Stroke	yes	no	_____
Breast disease	yes	no	_____
Kidney disease	yes	no	_____
Seizures or neurologic disorders	yes	no	_____
Hepatitis or liver disease	yes	no	_____
Problems with anesthesia	yes	no	_____
Osteoporosis	yes	no	_____
Other			_____

ADDITIONAL INFORMATION:_____
_____
_____
_____

Patient's Signature:_____ Date:_____

Practitioner's Signature:_____ Date:_____