New Patient Form

New Patient History

Patient Name: ____Date____________________

Address: ____

Email Address (personal): _________________________ (work): ______________________________

Home Phone: (_____)______________________ Work Phone: (_____)_____________________________

Date of Birth: ____________________________ Social Security Number: _________________________

Present Symptoms

Main Reason for Visit		
Symptoms (circle any that apply)	General/Constitutional	Weight loss Weight gain Fever Night sweats
	Eyes	Double vision Tearing Blind spots Eye pain
	Ears/Nose/Mouth/Throat	Headaches Dizziness Lightheadedness Nose bleeding Nasal obstruction Dental difficulties Bleeding gums Dentures Neck stiffness Neck pain Neck tenderness Neck mass
	Cardiovascular	Chest pain Irregular heart beat Fainting Shortness of breath with exertion Shortness of breath lying down Shortness of breath when waking at night Swelling High blood pressure Heart murmur Varicosities Phlebitis Painful extremity with movement
	Respiratory	Wheezing Cough Coughing blood Respiratory infections Tuberculosis
	Gastrointestinal	Poor appetite Difficulty swallowing Indigestion Abdominal pain Heartburn Burping Nausea Vomiting Vomiting blood Yellow skin Constipation Diarrhea Abnormal stools Flatulence Hemorrhoids Recent changes in bowel habits
	Genitourinary	Urgency Frequency Painful urination Getting up at night to urinate Blood in Urine Frequent urination Lack of urine Stones Urinary incontinence Urinary infections Nephritis Vaginal discharge Venereal disease
	Musculoskeletal	Joint pain Limitation of motion Muscular weakness Muscle cramps
	Skin/Breast	Rash Itching Pigmentation Changes in hair growth or loss Nail changes Breast lumps Breast tenderness Breast swelling Nipple discharge
	Neurologic	Convulsions Paralysis Tremor Incoordination Difficulties with memory or speech Sensory or motor disturbances Problem with muscular coordination
	Psychiatric	Nervousness Emotional problems Anxiety Depression Previous psychiatric care Hallucinations
	Endocrine	Increased water intake Hormone therapy Abnormal growth Intolerance to heat or cold
	Hematology/Lymphatic	Anemia Bleeding tendency Previous transfusions and reactions Rh incompatibility Lymph node enlargement or tenderness
	Allergic/Immunologic	Reactions to drugs Reaction to food Reaction to insects

Family History (Mark Those That Apply)

Disease	Father	Mother	Maternal Grandparents		Paternal Grandparents		Brothers / Sisters				Children
			Grandmother	Grandfather	Grandmother	Grandfather					
Living or Deceased (Age)	( )	( )	( )	( )	( )	( )					
Alcoholism											
Anemia											
Arthritis											
Asthma											
Bleeds Easily											
Cancer (type)											
Colon Polyps											
Diabetes											
Epilepsy											
Glaucoma											
Heart Disease											
High Cholesterol											
High Blood Pressure											
Kidney Disease/Stones											
Mental Illness											
Obesity											
Osteoporosis											
Stomach Ulcers											
Stroke											
Suicide											
Thyroid Disease											
Tuberculosis											
Other Inherited Disease											

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New Patient Form

Prior Medical, Surgical, and Obstetrical History

Medical History

Please list all significant prior medical illnesses and current medical problems for which you are under medical treatment:

Surgical History

Please list all surgical procedures you have had and the year they were performed:

Year	Procedure

Obstetrical History

Please list all pregnancies you have had including miscarriages and ectopic pregnancies

Year	Mode of delivery	Gestational age	Sex	Weight	Complications

Medications and Allergies

Medications

Please list all current medications:

Medication	Dosage	Frequency	Use

Allergies

Please list all medication allergies:

Gynecologic History

Age at first period:		When was your last period?		When was the period before that?	
How far apart are your cycles?				How many days do they last?	

Circle any symptoms associated with your periods:
cramps heavy flowclots headaches breast tenderness change in mood pelvic pain

Circle your current forms of birth control: none birth control pills IUD diaphragm spermicide Nuva Rung
depoprovera injections Natural family planning tubal ligation vasectomy condoms

Have you ever had an abnormal pap smear?	__ NO	__ YES	List any treatment for an abnormal pap smear:		
Do you desire pregnancy at this time?	__ NO	__ YES	Do you examine your breasts every month?	__ YES	__ NO
Do you have pain with intercourse?	__ NO	__ YES	Do you have bleeding after intercourse?	__ NO	__ YES
Do you use douches?	__ NO	__ YES	Have you stopped having periods?	__ NO	__ YES
Are you currently sexually active?	__ NO	__ YES	Total number of sexual partners in the past:		

Sexual Preference (circle one): heterosexual lesbian bisexual

Have you ever had a sexually transmitted disease?	__ NO	__ YES	If yes, which ones: gonorrhea chlamydia herpes PID syphilis HIV hepatitis B genital warts

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New Patient Form

Screening

Pap Smear: The pap smear is a test that is performed to diagnose pre-cancerous changes of the cervix. Cancer of the cervix is a deadly disease that does not just appear overnight. It is generally proceeded by a process called dysplasia. This is easily diagnosed by pap smear and can be cured with very conservative measures. The pap smear is obtained by placing a speculum into your vagina and exposing the cervix. A wooden spatula and a cervical brush are used to sample cells from your cervix. The American College of Obstetricians and Gynecologists recommend this test be performed after a woman becomes sexually active or when she reaches 18 years of age, whichever comes first. The test should be performed every year until 3 consecutive normal smears are obtained. For low risk patients, the interval of pap smears can be spaced out at your and your doctor's discretion.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Hemoglobin: This is a blood test that measures the red blood cell volume in your blood stream. These cells are important for carrying oxygen in your body. A specimen is obtained by inserting a needle into a vein in your arm. Many processes can cause anemia, a condition where the hemoglobin is low. One of the most common causes of anemia is chronic bleeding like heavy menstrual periods or bleeding from the gastrointestinal tract. Other causes of anemia are inherited, due to chronic diseases, or due to poor diet. The American College of Obstetricians and Gynecologists recommend that people of Caribbean, Latin American, Asian, Mediterranean, or African Ancestry have this screening examination performed. Women with heavy menstrual flow should be screened as well.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Urine Culture: Bacteria growing in the urine can easily be treated. Many women with infection in the urine present with symptoms like painful or frequent urination. Others don't have any symptoms. Diabetic patients are more likely to be harmed by chronic infections in the urine. The American College of Obstetricians and Gynecologists recommend that diabetics be screened.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Mammogram: A mammogram is your best tool to detect breast cancer early. Early detection of breast cancer is the key to cure of this type of cancer. This is an xray of the breast that needs to be scheduled. It will not be performed on the date of the annual examination. The American College of Obstetricians and Gynecologists recommend that women with a sister, mother, or daughter diagnosed with breast cancer prior to menopause have a mammogram at 35 years of age. After 40 years of age, all women should be screened every 1-2 years. After 50, the test should be done every year.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Fasting Glucose: Diabetes is a disease characterized by a high blood sugar. This problem can result in many complications like blindness, heart disease, amputations, kidney failure, and strokes. Early diagnosis and treatment can delay or prevent these problems. This test is obtained by drawing blood from a vein in your arm after fasting overnight. The American College of Obstetricians and Gynecologists recommend that this test be performed every 3-5 years in people who have a family history of diabetes, are obese, or developed diabetes in a previous pregnancy.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Cholesterol: Cholesterol, if elevated, can result in blockages in your arteries. This can result in heart attacks. High cholesterol can be a result of inheritance or dietary factors. A high cholesterol can be lowered with lifestyle change, or if needed, with medication. This test is done by drawing blood from a vein in your arm. The American College of Obstetricians and Gynecologists recommend that this be tested every five years starting at 45 years of age. It should be done earlier in patients who have a personal or family history of premature coronary artery disease or in patients with a history of lipid disease in the family.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Tests for sexually transmitted disease: Persons with one sexually transmitted disease are at risk for developing other sexually transmitted disease. These diseases include hepatitis B, HIV, syphilis, gonorrhea, and chlamydia. The tests are both blood tests that require blood be drawn from a vein in your arm plus a specimen obtained from your cervix at the time of a pelvic examination. The American College of Obstetricians and Gynecologists recommend that a woman with more than one sexual partner, or who has a partner, who has more than one partner, should consider being tested for sexually transmitted diseases.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Rubella Immunity: Rubella is a viral infection that can cause a rash and fever. If you catch rubella during pregnancy, the fetus may develop a number of severe birth defects. This is completely preventable by vaccination. The American College of Obstetricians and Gynecologists recommend that if you have a testing of rubella immunity if you are of childbearing age and have not previously been documented to be immune. This test is a blood test and the sample is taken from a vein in your arm.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Tuberculosis Skin Test: Tuberculosis is a serious public health issue. This disease is a lung infection that if left untreated is contagious and can cause death. With the emergence of the HIV epidemic, tuberculosis has made a comeback. The American College of Obstetricians and Gynecologists recommend that you be tested if you are HIV positive, in close contact with people who have known or suspected tuberculosis, if you have medical problems that make you more susceptible to complications if you contract the disease, abuse alcohol, use intravenous drugs, you are a resident of a long-term care facility (i.e., prison, mental institution, or nursing home), or work in a high-risk health care facility. This test is done by injecting a small amount of fluid into the skin of your forearm. The test needs to be read in the office at 48 to 72 hours after the injection.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Lipid Profile: The American College of Obstetricians and Gynecologists recommend a lipid profile if your screening cholesterol is elevated, if you have a parent or sibling with elevated cholesterol, if you have diabetes, if you smoke, or if you have a close relative with premature coronary artery disease. This test will break down your cholesterol count into the good (HDL) and bad (LDL) cholesterol and get a more accurate reflection of the risk of developing coronary artery disease. This is a blood test the requires drawing a sample from a vein in your arm.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Thyroid Stimulating Hormone: This is a test of a gland in your neck that regulates your metabolism. This is tested by drawing blood from a vein in your arm. The American College of Obstetricians and Gynecologists recommend that this test be offered to patients with a strong family history of thyroid disease or a personal history of autoimmune disease.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Fecal Occult Blood: This is test for blood in your stool. Blood in the stool is an early warning sign of cancer of the gastrointestinal tract. You will be given a card that requires 3 separate specimens of your stool be collected and sent back for analysis. The American College of Obstetricians and Gynecologists recommend that you should be tested every one to two years until 50 years of age and then annually after age 50.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Sigmoidoscopy: An additional screening tool for colon cancer is to directly observe the lower colon with a lighted scope. This procedure is generally performed by a physician with special training and might need to be scheduled. The American College of Obstetricians and Gynecologists recommend that this be performed every three to five years after the age of 50.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

Colonoscopy: To screen for colon cancer the entire length of the colon can be observed with a lighted scope. This procedure is generally performed by a physician with special training and might need to be scheduled. The American College of Obstetricians and Gynecologists recommend that colonoscopy be performed in patients with a history of inflammatory bowel disease or colon polyps or a family history of familial polyposis, colon cancer, or cancer family syndrome.

_____ I do not need this test	_____ I had this test date: _______________	____ I believe that I need this test

**If you have had a colonoscopy, please describe where the test was administered, when you had the test, and indicate your results (please use the back of this page).
**If you have had a mammogram, please describe where the test was administered, when you had the test, and indicate your results (please use the back of this page).

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Immunizations

Tetanus Booster: A tetanus shot is important to prevent a potentially fatal disease called tetanus, more commonly referred to as lockjaw. The American College of Obstetricians and Gynecologists recommend that you be vaccinated every ten years.

____ I do not need this vaccination	____ I had this vaccination date: ________	____ I believe that I need this vaccination

Rubella vaccine: The American College of Obstetricians and Gynecologists recommend this vaccine be given to women of childbearing age who are not immune to rubella. Rubella, if contracted in early pregnancy, has devastating effects on the fetus. This is completely preventable.

____ I do not need this vaccination	____ I had this vaccination date: ________	____ I believe that I need this vaccination

Hepatitis B vaccine: This is potentially fatal infection of the liver. It is preventable with a series of three vaccinations. The American College of Obstetricians and Gynecologists recommend this vaccine be given to women whose jobs expose them to blood and body fluids. Other candidates for this vaccine include intravenous drug users, patients who receive blood products, people who have household or sexual contact with hepatitis B virus carriers, prostitutes, and people with multiple sexual partners.

____ I do not need this vaccination	____ I had this vaccination date: ________	____ I believe that I need this vaccination

Influenza vaccine: The influenza virus causes a self-limited respiratory infection in most people. However, elderly or ill people can develop fatal complications from infection. The American College of Obstetricians and Gynecologists recommend this vaccine be administered annually prior to the flu season starting at 55 years of age. Other candidates for the vaccine include residents of chronic care facilities, patients with cardiac or metabolic diseases (ex, diabetes, kidney disease), patients whose immune systems are compromised, and pregnant women in the second and third trimester.

____ I do not need this vaccination	____ I had this vaccination date: ________	____ I believe that I need this vaccination

Pneumococcal vaccine: A bacterial infection that causes pneumonia and meningitis caused by a streptococcus can be prevented by vaccination. The American College of Obstetricians and Gynecologists recommend this vaccine be given once lifetime to residents of chronic care facilities, patients with cardiac or metabolic diseases (ex, diabetes, kidney disease), patients whose immune systems are compromised, patients with sickle cell disease, Hodgkin's disease, alcoholism, cirrhosis, or multiple myeloma.

____ I do not need this vaccination	____ I had this vaccination date: ________	____ I believe that I need this vaccination

Varicella vaccine: Chicken pox is a self-limiting viral infection. In adults, the disease can be more severe and result in a potentially fatal lung infection. This is more likely to happen if the disease is contracted in pregnancy. The American College of Obstetricians and Gynecologists recommend this vaccine be given to women of childbearing age who are not already immune.

____ I do not need this vaccination	____ I had this vaccination date: ________	____ I believe that I need this vaccination

Social History

Do you smoke cigarettes?	___ NO	___ YES	If so, how many cigarettes per day?		
Do you drink alcohol?	___ NO	___ YES	If so, how many drinks per week?		
Do you use drugs?	___ NO	___ YES	If so, which ones?		
Do you use seatbelts?	___ YES	___ NO	Do you exercise?	___ YES	___ NO
Have you ever received a blood transfusion?	___ NO	___ YES	Are you under a lot of stress?	___ NO	___ YES
Place of birth:			If you were not born in this country, how long have you lived here?		

Health Questionnaires

Partner Violence Questionnaire					
Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If so, by whom? ____________				___ NO	___ YES
Do you feel unsafe in your current relationship?				___ NO	___ YES
Is there a partner from a previous relationship who is making you feel unsafe now?				___ NO	___ YES
Depression Questionnaire					
I am unable to do the things I used to do.	___ NO	___ YES	I feel hopeless about the future.	___ NO	___ YES
I can't make decisions.	___ NO	___ YES	I feel sluggish/restless.	___ NO	___ YES
I am gaining/losing weight.	___ NO	___ YES	I get tired for no reason.	___ NO	___ YES
I am sleeping too little (or too much).	___ NO	___ YES	I feel unhappy.	___ NO	___ YES
			I think about killing myself.	___ NO	___ YES
Genetic Screening Questionnaire (Answer if you are of child bearing age and interested in pregnancy)					
Have you, your partner, or anyone in either of your families ever had any of the following disorders:					
-- Down Syndrome	___ NO	___ YES	-- Any chromosomal abnormality	___ NO	___ YES
-- Spina Bifida or anencephaly	___ NO	___ YES	-- Hemophilia	___ NO	___ YES
-- Muscular Dystrophy	___ NO	___ YES	-- Cystic fibrosis	___ NO	___ YES
-- If yes, what relationship:					
Do you, your partner, or anyone in either of your families have a chromosomal disorder not listed above?				___ NO	___ YES
Do you or your partner have a birth defect?				___ NO	___ YES
Are you and your partner blood relatives?				___ NO	___ YES
In any previous marriages, has you or your partner had a stillborn child or three first trimester pregnancy losses?				___ NO	___ YES
Are you or your partner of Jewish or Cajun ancestry?				___ NO	___ YES
Are you or your partner Hispanic or African American?				___ NO	___ YES
Are you or your partner of Italian, Greek, or Mediterranean ancestry?				___ NO	___ YES
Are you or your partner of Philippine, Chinese, or Southeast Asian ancestry?				___ NO	___ YES

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New Patient Form

Health Questionnaires (cont.)

Urinary Incontinence Questionnaire (answer if you are having difficulty with urinary incontinence)

Group 1:		
Have you had treatment for urinary disease, such as stones, kidney disease, infections, tumors, or injuries?	___ NO	___ YES
Have you had repeated bouts of pyelitis?	___ NO	___ YES
Is your urine ever bloody?	___ NO	___ YES
Circle the usual volume of urine you void: large average small very small		
When you lose your urine accidentally, are you ever unaware that it is passing?	___ NO	___ YES
Do you have a severe sense of urgency before you lose your urine?	___ NO	___ YES
Do you lose urine as a constant drip from the vagina?	___ NO	___ YES
Did you have difficulty holding urine as a child?	___ NO	___ YES
Is it usually painful or difficult to pass your urine?	___ NO	___ YES
Group 2:		
Did you wet the bed as a child?	___ NO	___ YES
Do you wet the bed now?	___ NO	___ YES
Circle any of the diseases you might have had: paralysis polio multiple sclerosis a serious injury to your back a cyst or tumor on your spine tuberculosis a stroke syphilis diabetes pernicious anemia		
Does the sound, sight, or feel of running water cause you to lose urine?	___ NO	___ YES
Is your loss of urine a continual drip, so that you are constantly wet?	___ NO	___ YES
Are you ever unaware that you are losing, or are about to lose, control of your urine?	___ NO	___ YES
Is your clothing slightly damp, wet, or soaking wet, or do you leave puddles on the floor? (if yes, circle one)	___ NO	___ YES
Have you had an operation on your spine, brain, or bladder?	___ NO	___ YES
Do you find it necessary to have your urine removed frequently by means of a catheter because you are unable to pass it?	___ NO	___ YES
Group 3:		
Do you lose urine by spurts. during coughing, sneezing, laughing, or lifting?	___ NO	___ YES
Do you lose urine when you are lying down?	___ NO	___ YES
Do you lose urine when you are sitting or standing erect?	___ NO	___ YES
When you are urinating, are you unable to stop the flow?	___ NO	___ YES
Did your urine difficulty start after delivery of an infant?	___ NO	___ YES
Did your urine difficulty start after an operation?	___ NO	___ YES
If so, circle the type of operation: Hysterectomy, abdominal incision Hysterectomy, removed through the vagina Removal of a tumor, abdominal incision Vaginal repair Suspension of the uterus Cesarean birth		
If your menstrual periods have stopped, did the menopause make your condition worse?	___ NO	___ YES
Do you have difficulty holding urine if you suddenly stand erect from a sitting or lying position?	___ NO	___ YES
Do you find it necessary to wear protection because you get wet?	___ NO	___ YES

Pelvic Relaxation Questionnaire

Do you have a sensation that organs are falling out from your vagina?	___ NO	___ YES
Do you need to put a finger in your vagina to allow a bowel movement?	___ NO	___ YES
Do you feel that your rectum is not empty after a bowel movement?		
Do you have a feeling of pelvic heaviness, especially with prolonged standing?	___ NO	___ YES

Osteoporosis SCORE (ages 50 and over only)

	Answer:	Weight:		Math:
Your Age:		First digit in age multiplied by 3		
Race:		0 if African American, 5 if other	+	
Have you ever been diagnosed with rheumatoid arthritis?		If yes, enter 4 points	+	
Since age 45 have you ever broken your hip, rib, or wrist?		If yes, 4 points for EACH	+	
Do you currently take or have you taken estrogen?		If no, enter 1 point	+	
		Subtotal:	=	
Your current weight in pounds:		Divide by 10 and subtract from subtotal	-	
		Total osteoporosis SCORE:	=	

Is the total of the osteoporosis SCORE 6 or higher?	___ NO	___YES

Alcohol Questionnaire

Have you ever felt you ought to cut down on your drinking?	___ NO	___ YES
Have people annoyed you by criticizing your drinking?	___ NO	___ YES
Have you ever felt bad or guilty about your drinking?	___ NO	___ YES
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	___ NO	___ YES

Planning Questionnaire

Do you have a durable power of attorney?	___ YES	___ NO
Have you made a living will?	___ YES	___ NO

New Patient Form

List ALL drugs, medications, and/or natural supplements you use regularly
(include birth control pills and non-prescription items - laxatives, pain pills, cold tablets, etc.):
____

____

Personal Profile

Number of Living Children	
Number of People in Household	
Marital Status	
Current or Most Recent Job	
Level Of Education Completed	

Personal High Risk Criteria

Have you had a pap smear in the last 7 years?	Yes / No
Have you ever had an abnormal pap smear test?	Yes / No
Did you begin sexual activity before you were 16 years old?	Yes / No
Have you had more than 5 sexual partners in your lifetime?	Yes / No
Have you ever tested positive for the HIV virus?	Yes / No
Did your mother take the drug DES while she was pregnant with you?	Yes / No

General Health

Please describe your weekly physical activity (what, how long, how often)?______________________________

____

I have included all pertinent information regarding my health history. YES / NO

I have additional health issues that were not addressed on this form. YES / NO

-If yes, please explain:

____

____

____

Completed by: Patient Office Nurse Physician

____ ____ Patient or Representative Name (Please Print) Patient or Representative Signature

____
Date reviewed by physician with Patient

Annual Review of History:

Date Reviewed:________________ Physician Signature:____

Date Reviewed:________________ Physician Signature:____

Date Reviewed:________________ Physician Signature:____

Date Reviewed:________________ Physician Signature:____

Date Reviewed:________________ Physician Signature:____

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