

NEW PATIENT FORM

Primary Care Doctor_____

Thank you for taking the time to complete this paperwork. It will help us to provide you with the best possible care. Please complete this form prior to your visit and bring it with you to your appointment.

NAME _______

Referring Doctor _____

OB History				
Total number of pregna	ncies	Number of Vaginal deliveries		
Full term births Preterm pregnancies Abortions		Number of C-sections		
		Number of Forceps deliveries		
		Weight of largest baby		
Living children				
GYN History				
Date of Last Menstrual	Period	Please check all that apply:	None	
How far apart (days)		Bladder surgery	Chlamydia	
Length of periods (days	3)	Prolapse surgery	Gonorrhea	
Last pap smear Last mammogram Menopause Yes No If yes, age Any gynecological problems?		Removal of ovaries	Herpes Genital warts Syphilis or HIV Abnormal pap	
		Hysterectomy		
		Ectopic pregnancy		
		Pelvic inflammatory disease		
Medical History (che Heart Disease	ck all that apply) None High blood pressure	Surgical History (attach list if needed) Operation	Year	None
Diabetes	High cholesterol	Operation	i Gai	
Asthma	Glaucoma			
Blood clots	Kidney infection			
Anxiety	Kidney stones			
Depression	Cancer, type:			
Бергеззіон	Garicer, type.			
Other Medical Probl	ems (attach list if needed)			
				
Family History Have any of your first-d	egree family members (parents,	siblings or children) had the following?		None
	Relative		lative	
Heart disease		Breast cancer		
High blood pressure		Ovarian cancer		
High cholesterol		Colorectal cancer		
Diabetes		Other cancer		

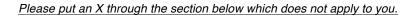
Social History						
	Single	Married	Partner	Divorced	Separated	Widowed
Occupation						
Sexually active	Yes	No How o	ften			
Exercise	Yes	No How o	ften			
Alcohol use	Yes	No Type		How often		
Drug use	Yes	No Type		How often		
Current Smoker	Yes	No Packs	per day	Age started		
Former smoker	Yes	No Packs	per day	Age started		Age quit

n a sheet.		None
Dosage/Frequency	Purpose	
		·

Allergies	None
Туре	Reaction

Review of Systems Have you exp	erienced any of these symptoms within the past four w	veeks? None
General	Lungs	Endocrine
Weight loss	Shortness of breath	Hot flashes
Fatigue	Wheezing	Night sweats
Fever or chills	Cough frequently	Excessive water intake
	Cough up blood	Excessive urine output
Skin		·
Rashes	Breast	Muscuskeletal
Itching	Breast lump	Joint pain
Hair and nail changes	Breast tenderness	Back pain
Abnormal mole	Nipple discharge	Muscle weakness
Eyes	Cardiac	Neurological
Vision loss/changes	Chest pain	Frequent headaches
Glaucoma	Heart fluttering	Passing out
Cataracts	-	Dizziness
	Gastrointestinal	Blurred vision
Ears Nose Mouth	Nausea	Numbness
Decreased hearing	Vomiting	
Mouth ulcers	Diarrhea	Psychiatric
Sore throat	Heartburn	Depression
Dry mouth	Pain with swallowing	Alcoholism
Snoring	Constipation	Anxiety
-	Rectal bleeding	Mood swings

Genitourinary system





Please answer the questions in the box if you have ANY problem with urine leakage or urination:

1 year
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Please answer the questions in the box if you have ANY problem with the vagina or bowel:

Vagina						
1. Do you experience pressure in the vagina?					No	
2. Do you have a bulge or something falling out that you can see or feel in your vaginal area? 3. Do you ever have to push on the vagina to start or complete urination?					No	
					No	
4. Do you ever have to push on the vagina or around the rectum to have a bowel movement?				Yes No		
5. Do you experience a feeling of incomplete bladder emptying?					No	
6. Do you have pain/discomfort during sexual activity?				Yes	No	
If yes, how often? always	sometimes	never				
Bowel						
1. How are your bowel movements?	normal	constipated	diarrhea	V	/ariable	
2. Do you leak stool or gas accidentally dur	ing the following	(check all that apply)?				
before reaching the toilet without	ut warning	without knowing	with loose sto	ols v	with formed sto	ols
3. Do you strain to have a bowel movemen	t? alw	ays most of	the time	sometime	s	never
4. Do you use laxatives or stool softeners?				Yes		No
5. Do you take any anti-diarrheal meds like loperamide (Imodium)?				Yes		No

Thank you for taking the time to complete this form!!!