ALL WOMEN OB/GYN P.S.C.

All Women OB/GYN, P.S.C.
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New Patient History (Please complete both pages of form)

Patient Acct#:______________________

Name:____ **Date:**______________________

Date of Birth:______________ **Marital Status:** _______________ **(**Single, Married, Widowed, Divorced, Other**)**

Patient's Employer:____**Occupation:**______________________________________

Partner's Name:____ **Occupation:**______________________________________

Partner's Employer:____

Emergency Contact:______________________________ **Phone #:** _______________________ **Relationship:**_____________

Reason for visit: ☐ Preventative/Well-Women Exam
Other: (Please explain)____

Who referred you?_________________________________ Name of Family Doctor:______________________________________

Medication History (List all medications that you currently take with the dose)

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Do you take hormone therapy or birth control pills? ☐ Yes ☐ No If YES, please list below

____ ____
____ ____

Allergies

(List all adverse reactions or allergies you have to medications and what happened)

____
____

Are you allergic to Latex?_______________ **Peanuts?:**_______________ **Eggs?**________________

Surgical History

(List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom tooth extraction including dates)

_________________________________Mo/Yr __________ _____________________________________Mo/Yr___________
_________________________________Mo/Yr __________ _____________________________________Mo/Yr___________
_________________________________Mo/Yr __________ _____________________________________Mo/Yr___________
_________________________________Mo/Yr __________ _____________________________________Mo/Yr___________

Medical History (Please list any medical problems that you have)

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

General Health

Height:______________ Weight:______________

Date/place of last pap smear:________________________________

Date/place of last mammogram:________________________________

How much alcohol do you drink? ☐None ☐Avg. less than 1/day ☐Avg. 1/day ☐ Avg. more

Do you smoke? ☐ Yes ☐ No Amount/day______________ How many years:______________

If you quit smoking, when did you stop? ________________________________

Gynecologic History

Age of first menstrual period:______________

Date of last menstrual period: ______________ ☐ Menopausal ☐ Hysterectomy

Length of cycle from 1st day to 1st day each month: days ☐ Regular ☐ Irregular

Average length of each period:______________ ☐ Heavy ☐ Moderate ☐ Light

What do you use to keep from getting pregnant? ☐Nothing ☐Vasectomy ☐ Condom ☐ Rhythm ☐ Tubal ligation ☐ IUD ☐Diaphragm ☐ Birth Control Pills ☐ Patch ☐ Abstinence

Sexual History

Are you sexually active ☐ Yes ☐ No

Pregnancy History

Age when you had your first child:______________

Number of times pregnant______________ Full term births______________ Premature Births ______________

Elective termination______________ Miscarriages ______________ Tubal pregnancies______________

Adopted children______________ Step children ______________ Twins______________

Have you ever had a C-Section? ______________

With any of your pregnancies, did you have: ☐ Gestational Diabetes? ☐Gestational Hypertension?

☐ Preeclampsia? Any Other complication? (please explain)________________________________

____

Family History ☐ **Adopted**

Does your mother(M), father(F), sister(S), brother(B), Grandmother(GM), and/or Grandfather(GF) have any of the following?

Increased cholesterol	☐ Yes	☐ No	who?______________
Diabetes	☐ Yes	☐ No	who?______________
Increased blood pressure	☐ Yes	☐ No	who?______________
Heart attack before age 50	☐ Yes	☐ No	who?______________
Breast cancer	☐ Yes	☐ No	who?______________
Colon cancer	☐ Yes	☐ No	who?______________