New Patient History

Name: _____
Date of Birth: _____
Preferred Pharmacy: _____
Who referred you to our office: _____

Last Menstrual Period: _____ (Regular or Irregular) or Post-Menopausal ?
Current Birth Control: (Circle One) None Tubal Hysterectomy Menopause Vasectomy IUD
Birth Control Pill Condoms Nexplanon NuvaRing Abstinence Depo Provera
Are you Sexually Active: (Circle One) Yes or No **Sexual Orientation:** Heterosexual Homosexual Bisexual
Primary Care Doctor: _____
Date of Last Pap Smear: _____ **Normal or Abnormal**
If you have had an Abnormal pap smear, what is the date of last abnormal pap and treatment used: _____
Treatment Used: Colposcopy Biopsy of Cervix Cervical Cone LEEP CRYO/ FREEZING
Date of Last Mammogram: _____ Normal or Abnormal
Location of Last Mammogram: (Circle One) St. Francis CDC Bridgeway Pink Monarch BCC
Date of Last Colonoscopy : _____ (If unsure please write 3, 5, 10 years ago etc)
Date of Last Dexa Scan (Bone Density) for Osteoporosis Screening : _____
Dexa Scan: (Circle One) Normal or Abnormal **Location of Last Dexa Scan:** _____

Current Medications: Please list name of medication, dosage, and how often you take it:

Allergies to Medications: _____
Age of Menarche? (Age you started your cycle) _____
Age or Onset of Menopause? _____
STD History: (Circle if you have had exposure to any of the following)
Gonorrhea Chlamydia Trichomonas Genital Herpes HIV Condyloma HPV on Pap Smear

Do you have a family history of Breast or GYN Cancer? (Circle One) **NONE Breast Uterine Ovarian Cervical**
If Yes, Please list family member with Cancer _____ **Maternal or Paternal**
If Yes, How old were they at the time of their diagnosis? _____
If Yes to Breast Cancer, did you or your family member get BRCA tested? (Circle One) **Yes or No**
Did you complete the Gardasil Vaccine (HPV)**?** (Circle One) **Yes or No** (series of 3 injections over 6 months)

Family History	**Diabetes**	**Hypertension**	**Stroke**	**Heart attack**	**Cancer**
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Aunt/ Uncle					

Do you have any of the following medical Problems? Check the box for you NOT your family

Cardiovascular	**Mental Health**	**GI/ Bowel**
☐ Arrhythmia (Irregular Heartbeat) ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Coronary Artery Disease ☐ Hyperlipidemia ☐ Hypertension (High Blood Pressure) ☐ History of DVT (Blood Clot in Leg) ☐ Mitral Valve Prolapse ☐ Myocardial infarction (Heart Attack) ☐ Pacemaker ☐ Peripheral Vascular Disease ☐ Valvular Heart Disease ☐ Other:	☐ Anxiety/ Depression ☐ Other:	☐ Crohn's Disease ☐ Colon Polyps ☐ GERD ☐ Hiatal Hernia ☐ Irritable Bowel Syndrome (IBS) ☐ Ulcerative Colitis ☐ Other:
	Orthopedics	**urology**
	☐ Arthritis ☐ Fibromyalgia ☐ Joint Problems ☐ Other:	☐ Hematuria ☐ Interstitial Cystitis ☐ Kidney Stones ☐ Recurrent UTI ☐ Renal Failure ☐ Incontinence ☐ Other:
Hematology/ oncology	**Endocrinology**	**Neurology**
☐ Anemia ☐ Breast Cancer ☐ Cervical Cancer ☐ Colon Cancer ☐ Endometrial Cancer ☐ Leukemia ☐ Lymphoma ☐ Lung Cancer ☐ Lupus ☐ Melanoma ☐ Ovarian Cancer ☐ Other Skin Cancers:	☐ Diabetes ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Insulin Resistance ☐ Morbid Obesity ☐ Polycystic Ovarian Syndrome (PCOS) ☐ Other:	☐ Migraine Headaches ☐ Multiple Sclerosis ☐ Seizure Disorder ☐ Stroke ☐ TIA ☐ Other: ☐

	G= Number of times you have been pregnant		Number of terminations
	P= Number of Live Births		SVD= Number of Vaginal Deliveries
	Number of Miscarriages		C/S=Number of C- Sections
	Number of Ectopic Pregnancies		
	Number of Adopted Children		

Have you had any of the following surgeries or Procedures?

Hysterectomy Date of Surgery: _____ ☐ Abdominal ☐ Vaginal ☐ Laparoscopic Assisted ☐ Supracervical	Number of C- Sections:	☐ Appendectomy (Appendix Removed) ☐ Cholecystectomy (Gallbladder Removed) ☐ Exploratory Surgery
Oophorectomy (Ovaries Removed): Date of Surgery: _____ ☐ Left ☐ Right ☐ Bilateral (Both)	**Tubal Ligation** Date of Surgery: _____ ☐ Laparoscopic ☐ Post-Partum ☐ Adiana ☐ Essure	**ENT** Date of Surgery: _____ ☐ Tonsillectomy ☐ Adenoidectomy
Vaginal Prolapse Surgeries: Date of Surgery: _____ ☐ Anterior/ Posterior Repair ☐ Bladder Tack	**Urologic procedures:** Date of Surgery: _____ ☐ Sling ☐ Cystoscopy ☐ Lithotripsy (Removal of Stones	**Orthopedic Surgeries:** Date of Surgery: _____ ☐ Arthroscopy ☐ Joint Replacement ☐ Repair Fracture ☐ Other:
Other GYN Surgeries ☐ Exploratory Laparoscopy ☐ Cystectomy (Ovarian Cyst Removed) ☐ Hysteroscopy ☐ Laparoscopy ☐ Myomectomy (Fibroids Removed) Open Incision or Laparoscopic ☐ Uterine Ablation ☐ D&C (Dilation and Curettage) Details/ Complications:	**Breast Biopsies** Date of Procedure: _____ ☐ Benign Findings ☐ Benign Papilloma ☐ Cancer ☐ Fibroadenoma ☐ Fibrocystic Changes	**Cardiac Procedures:** Date of Procedures: _____ ☐ Angioplasty ☐ Cardiac Cath ☐ CABG ☐ Stent Placement ☐ Other:
Hernia Repair: Date of Surgery: _____ ☐ Incisional ☐ Inguinal ☐ Umbilical ☐ Other:	**Cosmetic procedures:** Date of Procedure: _____ ☐ Abdominoplasty ☐ Breast Augmentation ☐ Breast Reduction ☐ Facial Cosmetic Procedure ☐ Liposuction ☐ Other Body Cosmetic Surgeries:	**Mastectomy:** Date of Surgery: _____ ☐ Left ☐ Right ☐ Bilateral

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Smoking Status ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker # of Cigarettes Daily _____	Alcohol ☐ Never ☐ Rare ☐ Socially ☐ Few drinks per week ☐ Few drinks per month	Exercise ☐ Regular ☐ None Place of Employment: _____ Retired Unemployed Student