Women's Medical Center

New Patient Form

Name: _____ **Nickname**: _____

DOB: _____ Age: ___

Marital Status (please circle): Single Married Widowed Divorced In a relationship

Spouse/Significant Other Name: _____

Number of children: _____ **Lives with**: _____

Pets: _____

Occupation (please circle): Stay at home mom Unemployed Student Homemaker Retired

Employed Part time as _____ Employed Full time as _____

Highest Grade Finished: _____ **High School Diploma**: ☐Yes ☐No GED: ☐Yes ☐No

College Degree: _____

Ethnicity (please circle): African American Caucasian Hispanic Asian American

Native American Ashkenazi Jewish Other: _____

Religion (please circle): Christian Baptist Latter-day Saints Catholic Lutheran Mormonism

Lutheran Mormonism Judaism Islam Buddism Hinduism Muslim

Non-Religious Atheist

Do you exercise? ☐Yes ☐No If yes, what type of exercise? _____

How often do you exercise? _____

Are you sexually active? ☐Yes ☐ No How many partners do you currently have? _____

What type of contraception do you use (please circle)? Pill Patch Nuva Ring DepoProvera (shot)

Nexplanon (implanted in arm) IUD Condoms Other:_____

Do you smoke? ☐Yes ☐No If yes, how much a day? _____

Does anyone in the home smoke? ☐Yes ☐No If yes,do they smoke ☐Inside ☐Outside

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks do you have a week? _____

Have you ever used any type of illegal drugs? ☐Yes ☐No Date last used? _____

If yes, what kind and when? _____

Do you wear your seatbelt? ☐Yes ☐No ☐Occasionally

Do you feel safe at home? ☐Yes ☐ No

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New Patient Family History

Please mark the column if a family member has had the disease listed.	Mother	Father	Brother	Sister	Aunt	Uncle	Maternal Grand-Mother	Maternal Grand-Father	Paternal Grand-Mother	Paternal Grand-Father	Comments
Alive											
Deceased *Age of Death*											
Glasses											
Contact Lenses											
Alzheimer's/ Dementia											
Anemia											
Arthritis											
Asthma											
Blood clots in legs											
Cancer (Type/Age @ DX)											
Heart Disease											
Congestive Heart Failure											
High Cholesterol											
Depression											
Diabetes (Type I or II)											
Substance Abuse (Alcohol or Drugs)											
Gall Bladder Disease											
Gallstones											
Hearing Problems											
Hepatitis (A, B, or C)											
Hypertension											
Kidney Disease											
Lupus											
Migraines											
Obesity											
Osteoporosis											
Psychiatric Problems: Depressions Anxiety											
Scleroderma											
Stoke											
Thyroid Disease (hypo or hyper)											
Tuberculosis											
Other:											
No Known Health Issues											

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New Patient Past Medical History

	(Please Check if yes)	
Chemical Abuse	☐	
Surgery (List Below)	☐	
Trauma	☐	
Transfusion	☐	
Diabetes Mellitus	☐	
CVA/Hypertension	☐	
Thyroid Disease	☐	
Cardiac Disease	☐	
Multiple Gestation	☐	
Gallbladder Disease	☐	
Thromboembolic Disease	☐	
Anemia	☐	
Collagen Vascular	☐	
Tuberculosis	☐	
Cancer	☐	
Asthma/Bronchitis	☐	
Renal Disease	☐	
Migraines	☐	
Decreased Hearing	☐	
Decreased Vision	☐	
Hepatitis	☐	
Colitis	☐	
Seizure Disorder	☐	
Psychiatric Disorder	☐	
STD	☐	

Please list all surgerys you have ever had along with dates: _____

_____

_____

_____

_____

Mentral History:

How old were you when you first started your period? _____ Are your periods regular? ☐Yes ☐No

How many days between your period? ☐ Less than 21 ☐ 28-31 ☐22-27 ☐32-35 ☐35-42 ☐Other_____

How long do you bleed for? ☐1-2 days ☐3-4 days ☐5-6 days ☐7 or more days ☐Other_____

How is your flow? ☐Light ☐Moderate ☐Heavy ☐ Other_____ Date of your last period:_____

GYN History:

Have you ever had GYN surgery? ☐Yes ☐No

When was your last pap smear? _____ Have you ever had an abnormal PAP? ☐Yes ☐No

When was your abnormal PAP and what were the results? _____

Have you ever been diagnosed with an uterine anomaly? ☐Yes ☐ No

Date of your last mammogram? _____ Were the results normal? ☐Yes ☐No

If no, what were the results and when? _____

Obstetrical History:

Have you ever had problems with infertility? ☐Yes ☐No

Have you ever been diagnosed with In utero DES exposure> ☐Yes ☐ No

Were you over 35 when you were pregnant? ☐Yes ☐ No

How many times have you been pregnant?_____ How many full term (37-40 wk) _____

How many preterm (20-36 wk)_____ Miscarriages:_____ Ectopic:_____ Terminations:_____

Have you tested positive for group B strep while pregnant? ☐Yes ☐ No

Please list all pregnancies you have ever had including vaginal, miscarriages, ectopics, abortions, or C-sections:

Date	Gestational Age at Delivery	Length of Labor	Type of Delivery (Vaginal, C-section, Miscarriage, Abortions, Ectopic)	Anesthesia	Sex	Weight	Complications	Provider that delivered	Location
					Male/Female				
					Male/Female				
					Male/Female				
					Male/Female				
					Male/Female				
					Male/Female				
					Male/Female				
					Male/Female				

Women's Medical Center

Medication and Allergies List

Allerigies

Medication Allery & Reaction	Food Allergy & Reaction	Environmental Allergy & Reaction

Prescription Medications

Medication Name	Dose	Frequency	How long have you taken?	Provider

Over-The-Counter Medications (include all pills, liquids, topical creams, etc)

Medication	How often	Used for?

Herbal or Natural Products (include all pills, liquids, topical products, etc)

Medication	How Often	Used For?

If you have any other questions or needed more space than what was provided, please list them here: