NEW PATIENT HISTORY

Name_____

Date of Birth_____

Preferred Pharmacy _____

Who referred you to our office_____

midtown OB•GYN
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DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS? (CHECK THE BOX FOR YOU, NOT YOUR FAMILY)

CARDIOVASCULAR		ENDOCRINOLOGY		HEMATOLOGY/ONCOLOGY		ORTHOPEDICS	
☐	Arrhythmia (irregular heart beat)	☐	Diabetes	☐	Anemia	☐	Arthritis
☐	Atrial Fibrillation	☐	Hyperthyroidism	☐	Breast Cancer	☐	Fibromyalgia
☐	Congestive Heart Failure	☐	Hypothyroidism	☐	Cervical Cancer	☐	Joint Problems
☐	Coronary Artery Disease	☐	Insulin Resistance	☐	Colon Cancer	☐	Other:
☐	Hyperlipidemia (Elevated Cholesterol)	☐	Morbid Obesity	☐	Endometrial Cancer	PULMONARY	
☐	Hypertension (High Blood Pressure)	☐	Polycystic Ovarian Syndrome	☐	Leukemia	☐	Asthma
☐	History Of DVT (Blood Clot In Leg)	☐	Other:	☐	Lymphoma	☐	COPD
☐	Mitral Valve Prolapse	GI/BOWEL PROBLEMS		☐	Lung Cancer	☐	History of Pulmonary Embolism
☐	Myocardial Infarction (Heart Attack)	☐	Crohn's Disease	☐	Lupus	☐	Pulmonary Fibrosis
☐	Pacemaker	☐	Colon Polyps	☐	Melanoma	☐	Sleep Apnea
☐	Peripheral Vascular Disease	☐	GERD (Gastroesophageal Reflux)	☐	Ovarian Cancer	☐	Other:
☐	Valvular Heart Disease	☐	Hiatal Hernia	☐	Other Skin Cancer (non melanoma)	UROLOGY	
☐	Other:	☐	Irritable Bowel Syndrome	☐	Other:	☐	Hematuria (blood in urine)
		☐	Ulcerative Colitis	NEUROLOGY		☐	Interstitial Cystitis
MENTAL HEALTH		☐	Other:	☐	Migraine Headaches	☐	Kidney Stones
☐	Depression / Anxiety			☐	Multiple Sclerosis	☐	Recurrent UTI (Bladder Infections)
☐	Other:			☐	Seizure Disorder	☐	Renal Failure (Kidney Failure)
				☐	Stroke	☐	Incontinence
				☐	TIA	☐	Other:
				☐	Other:		

OB GYN HISTORY:			PAP SMEAR HISTORY:			MMG HISTORY:		
		G = Number of Times You Have Been Pregnant	☐	Never Had PAP		☐	Never Had MMG	
		P = Number of Live Births	☐	No History of Abnormal PAPs		☐	No History of Abnormal MMG	
		Number of Miscarriages	☐	History of Abnormal PAPs		☐	History of Abnormal MMG	
		Ectopic Pregnancies			Date Diagnosed In			When
		Number of Adopted Children			or Age		☐	No Biopsy done
		Terminations		☐	OTHER:		☐	Benign Biopsy
		SVD=Number Of Vaginal Deliveries					☐	Cyst
		C/S = Number Of C-Sections					☐	Fibroadenoma
Largest Baby Weight		lbs oz					☐	Fibrocystic Changes
Problems with pregnancy?							Surgeon	
	☐	None		Procedures:		HISTORY OF SEXUALLY TRANSMITTED DISEASE?		
	☐	Gestational Diabetes		☐	Colposcopy		☐	Chlamydia
	☐	Abruption		☐	Cryo Surgery/Freezing		☐	Condyloma
	☐	Preeclampsia		☐	Cervical Cone		☐	Gonorrhea
	☐	Preterm Labor		☐	LEEP		☐	HIV
	☐	OTHER:		☐	Laser		☐	HSV Herpes
		Age at menarche (when you started periods)		☐	OTHER:		☐	HPV
		Age at menopause (age you stopped periods) if applicable					☐	Syphilis
							☐	Trichomonas

Current Birth Control Method _____

- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Not applicable
- ☐ List Other _____

Have you completed the Gardisil Series? ☐ Yes ☐ No

Date of Last PAP Smear: ☐ Normal ☐ Abnormal – specifics:

Date of Last Mammogramr: ☐ Normal ☐ Abnormal – specifics:

Place of Last Mammogram:

Date of Last Colonoscopy: ☐ Physician: ☐ Results:

Have you ever had a DEXA Scan (Bone Density) for Osteoporosis screening? ☐ Yes ☐ No

DEXA Scan: ☐ Normal ☐ Abnormal – specifics:

Date of DEXA Scan: Place of DEXA Scan:

OTHER MEDICAL PROVIDERS

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES? (ANSWER FOR YOU, NOT YOUR FAMILY)

☐ Hysterectomy	☐ D & C	☐ Breast Biopsy or Lumpectomy	☐ ENT
☐ Abdominal	Date: Or Age:	☐ Benign	☐ Tonsillectomy
☐ Vaginal		☐ Benign Papilloma	☐ Other:
☐ Laparoscopy Assisted	Details / Complications:	☐ Cancer	☐ Orthopedic
☐ Supracervical		☐ Fibroadenoma	☐ Arthroscopy
☐	☐ C-section	☐ Fibrocystic Changes	☐ Joint Replacement
☐ Ovaries Removed w/Hysterectomy	1 2 3 4 5 (circle # of times)	☐ Mastectomy	☐ Repair Fracture
☐ Yes	☐ Tubal Ligation	☐ Bilateral	☐ Other:
☐ No	☐ Laparoscopic	☐ Left	☐ Cosmetic Procedures
Date/Year: Or Age:	☐ Postpartum	☐ Right	☐ Abdominoplasty
	☐ Adiana	Date:	☐ Breast Augmentation
Reason:	☐ Essure	☐ Exploratory Surgery	☐ Breast Reduction
	Date: Or Age:	☐ Appendectomy	☐ Facial Cosmetic Procedure
		☐ Cholecystectomy	☐ Liposuction
☐ Other GYN surgery	☐ Urologic Procedures	☐ Hernia Repair	☐ Other Body Cosmetic Surgery
☐ Exploratory Laparotomy	☐ Sling	☐ Incisional	☐ Other:
☐ Hysteroscopy	☐ Cystoscopy	☐ Inguinal	
☐ Laparoscopy	☐ Lithotripsy	☐ Umbilical	
☐ Myomectomy (Removal Of Fibroids)	☐ Other:	☐ Other:	
Date:	☐ Vaginal Prolapse Procedures	☐ Cardiac Procedures	
☐ Open Incision	☐ Anterior Repair/Bladder Tack	☐ Angioplasty	
☐ Laparoscopy	☐ Other:	☐ Cardiac Cath	
☐ Uterine Ablation		☐ CABG	
☐ Oopherectomy (Removal Of Ovaries)		☐ Stent Placement	
☐ Both Ovaries		☐ Other:	
☐ Left Ovary			
☐ Right Ovary			
Date:			
Reason:			

FAMILY HISTORY (ANSWER THESE QUESTIONS FOR YOUR FAMILY, NOT YOU)

☐	My family history is unknown	If anyone in your **FAMILY** has ever had breast cancer answer the following:	Have any first degree relatives had colon cancer:	If anyone in your **FAMILY** has ever had other cancers check all that apply	
Members of my **FAMILY** have:		Mother - Age:	Mother - Age:	☐	Brain
☐	Blood clots	Father - Age:	Father - Age:	☐	Cervical
☐	Diabetes	Sibling(s) - Age:	Sibling(s) - Age:	☐	Endometrial
☐	Heart Disease	Other: Age:	Other: Age:	☐	Gastric
☐	Elevated Cholesterol			☐	Leukemia / Lymphoma
☐	Hypertension (high blood pressure)	Other: Age:	If anyone in your **FAMILY** has ever had ovarian cancer answer the following:	☐	Liver
☐	Stroke			☐	Lung
☐	Thyroid Disease	Other: Age:	Mother - Age:	☐	Melanoma
			Sibling(s) - Age:	☐	Pancreatic
		Other: Age:	Other: Age:	☐	Renal
				☐	Other:
		If the above relative(s) died from their cancer please list below:			

SOCIAL HISTORY

MARITAL STATUS:				ALCOHOL	
☐	Single			☐	None
☐	Married			☐	Rare
☐	Separated			☐	Social
☐	Divorced			☐	Few Drinks Per Week
☐	Widowed			☐	Few Drinks Per Month
☐	Same Sex Partner			☐	# of Drinks Per Day (circle #) 1 2 3 >3
☐	Other:			SMOKING STATUS	
OCCUPATION:				☐	Never Smoked
☐				☐	Previously Smoked
	Place of Employment :				# of Years:
☐	Unemployed	☐	Student		# of Packs Per Day:
☐	Homemaker	☐	Retired	☐	Currently Smoke Packs Per Day
☐	Disabled			EXERCISE	
	Due To:			☐	Regular
				☐	None
				☐	Other

CURRENT MEDICATIONS:

ALLERGIES:

IF YOU ARE OF CHILD BEARING AGE, DO YOU WANT ANY GENETIC TESTING DONE PRIOR TO PREGNANCY? ☐ YES OR ☐ NO

SPECIAL CONCERNS AT TODAY'S VISIT?