THE OB/GYN CENTRE
NEW PATIENT HISTORY

PERSONAL PROFILE	
NAME:________________________	NAME YOU WOULD LIKE US TO USE:________________
AGE:________________________	OCCUPATION:________________________
MARITAL STATUS:____________________	

GYNECOLOGICAL HISTORY		
LAST MENSTRUAL PERIOD (FIRST DAY):	PRESENT BIRTH CONTROL	
AGE PERIOD BEGAN:	PAST METHODS OF BIRTH CONTROL:	
NUMBER OF DAYS BLEEDING:	LAST PAP SMEAR:	RESULT:
NUMBER OF DAYS BETWEEN PERIODS:	ABNORMAL PAP IN THE PAST?____NO____YES (DATE)____________	
ANY RECENT CHANGES IN PERIODS?	LAST MAMMOGRAM:	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	ABNORMAL MAMMOGRAMS/BREAST BIOPSIES IN THE PAST?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	____NO____YES (DATE)____________	
SEXUAL ORIENTATION	DO YOU DO SELF BREAST EXAMS?	

OBSTETRIC HISTORY		

PLEASE LIST EACH PREGNANCY BELOW						
NO.	DATE	WEIGHT	SEX	WEEKS PREGNANAT	COMPLICATIONS	TYPE OF DELIVERY (VAG/C-SEC
1.						
2.						
3.						
4.						
5.						

CURRENT MEDICATIONS (INCLUDE VITAMINS, HERBS, ETC.) - CHECK HERE IF NONE					
DRUG NAME	DOSE	DRUG NAME	DOSE	DRUG NAME	DOSE
1.		2.		3.	
4.		5.		6.	

ALLERGIES - CHECK HERE IF NONE			
DRUG NAME	DOSE	DRUG NAME	DOSE
1.		2.	
4.		5.	

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SOCIAL HISTORY

CIGARETTES:___________NEVER:____________CURRENT:____________PAST:____________PACKS PER DAY:____________YEARS____________

ALCOHOL:___________NONE:____________# DRINKS PER DAY:____________# DRINKS PER WEEK

RECREATIONAL DRUGS (DESCRIBE):______________________CURRENT:___________________PAST

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?:__________ NO __________ YES

PERSONAL PAST HISTORY OF ILLNESS

ILLNESS	YES	NO	UNSURE	DETAILS (DATE/DESCRIPTION)
ASTHMA				
LUNG DISEASE/PNEUMONIA				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
HERPES				
OTHER SEXUALLY TRANSMITTED DISEASES				
HIV/AIDS				
HEART ATTACK/ANGINA				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LEGS OR LUNGS				
LUPUS/COLLAGEN VASCULAR DISEASE				
EATING DISORDER				
CHICKENPOX				
CANCER				
REFLUX/STOMACH ULCER				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSION				
SEIZURES				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PROBLEMS				
BROKEN BONES				

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ILLNESS (CONT.)	YES	NO	UNSURE	DETAILS (DATE/DESCRIPTION)
HEPATITIS/LIVER DISEASE				
THYROID DISEASE				
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS / HOSPITALIZATIONS

PROCEDURE/REASON HOSPITALIZED	DATE	HOSPITAL	COMPLICATIONS
1.			
2.			
3.			
4.			
5.			

INJURIES/ILLNESS

DATE	INJURY/ILLNESSES
1.	
2.	
3.	
4.	

FAMILY HISTORY

MOTHER___________LIVING____________DECEASED-AGE/CAUSE OF DEATH

FATHER___________LIVING____________DECEASED-AGE/CAUSE OF DEATH

SIBLINGS # LIVING___________ # DECEASES____________ AGE/CAUSE OF DEATH

CHILDREN # LIVING___________ # DECEASES____________ AGE/CAUSE OF DEATH

ILLNESS	YES	WHICH RELATIVES/AGES OF ONSET
DIABETES		
STROKE		
HEART DISEASE		
BLOOD CLOTS IN LEGS OR LUNGS		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
OSTEOPOROSIS		
HEPATITIS		
TUBERCULOSIS		

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ILLNESS	YES	WHICH RELATIVES/AGES OF ONSET
BIRTH DEFECTS		
ALCOHOL OR DRUG ADDICTION		
BREAST CANCER		
OVARIAN CANCER		
COLON CANCER		
UTERINE CANCER		
OTHER CANCERS		
MENTAL ILLNESS/DEPRESSION		
ALZHEIMER'S DISEASE		
OTHER		

REVIEW OF SYSTEMS

PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING SYMPTOMS

1. CONSTITUTIONAL	NOW	PAST	NEVER	NOTES
UNEXPLAINED WEIGHT LOSS				
UNEXPLAINED WEIGHT GAIN				
FEVER				
FATIGUE				
CHANGE IN HEIGHT				
2. EYES	NOW	PAST	NEVER	NOTES
DOUBLE VISION				
SPOTS BEFORE EYES				
VISION CHANGES				
GLASSES/CONTACTS				
3. EAR NOSE AND THROAT	NOW	PAST	NEVER	NOTES
EARACHES				
RINGING IN EARS				
HEARING PROBLEMS				
SINUS PROBLEMS				
SORE THROAT				
4. CARDIOVASCULAR	NOW	PAST	NEVER	NOTES
PAIN WITH BREATHING				
CHEST PAIN				
SHORTNESS OF BREATH				
IRREGULAR HEARTBEAT				

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5. RESPIRATORY	NOW	PAST	NEVER	NOTES
WHEEZING				
SPITTING BLOOD				
CHRONIC COUGH				
6. GASTROINTESTINAL	NOW	PAST	NEVER	NOTES
DIARRHEA				
BLOODY STOOL				
NAUSEA/VOMITING				
CONSTIPATION				
INVOLUNTARY LOSS OF STOOL				
7. GENITOURINARY	NOW	PAST	NEVER	NOTES
BLOOD IN URINE				
PAIN WITH URINATION				
STRONG URGENCY TO URINATE				
FREQUENT URINATION				
INCOMPLETE BLADDER EMPTYING				
INVOLUNTARY LOSS OF URINE				
URINE LOSS WITH COUGH/STRAIN				
ABNORMAL VAGINAL BLEEDING				
PAINFUL PERIODS				
PAINFUL INTERCOURSE				
FIBROIDS				
ENDOMETRIOSIS				
INFERTILITY				
ABNORMAL VAGINAL DISCHARGE				
8. MUSCULOSKELETAL	NOW	PAST	NEVER	NOTES
MUSCLE WEAKNESS				
MUSCLE OR JOINT PAIN				
9. SKIN	NOW	PAST	NEVER	NOTES
RASH				
SORES				
DRY SKIN				
MOLES				

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10. BREASTS	NOW	PAST	NEVER	NOTES
PAIN IN BREAST				
LUMPS				
NIPPLE DISCHARGE				
11. NEUROLOGIC	NOW	PAST	NEVER	NOTES
DIZZINESS				
SEIZURES				
NUMBNESS				
TROUBLE WALKING				
SEVERE MEMORY PROBLEMS				
SEVERE HEADACHES				
12. PSYCHIATRIC	NOW	PAST	NEVER	NOTES
DEPRESSION				
SEVERE ANXIETY				
13. ENDOCRINE	NOW	PAST	NEVER	NOTES
HAIR LOSS				
HEAT/COLD INTOLERANCE				
ABNORMAL THIRST				
HOT FLASHES				
14. HEMATOLOGY/LYMPHATIC	NOW	PAST	NEVER	NOTES
EASY BRUISING/EASY BLEEDING				
ENLARGED GLANDS				

PATIENT SIGNATURE: DATE:

PHYSICIAN REVIEW (INITIAL AND ANNUAL)

SIGNATURE: DATE:

SIGNATURE: DATE:

SIGNATURE: DATE:

SIGNATURE: DATE:

SIGNATURE: DATE:

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