



**THE OB/GYN CENTRE  
NEW PATIENT HISTORY**

<b>PERSONAL PROFILE</b>	
NAME:	NAME YOU WOULD LIKE US TO USE:
AGE:	OCCUPATION:
MARITAL STATUS:	

<b>GYNOCOLOGICAL HISTORY</b>	
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?

<b>OBSTETRIC HISTORY</b>					
	NUMBER		NUMBER		NUMBER
TOTAL PREGNANCIES		PREMATURE (< 37 WEEKS)		LIVING CHILDREN	
FULL TERM (37 – 42 WEEKS)		ABORTIONS		MISCARRIAGES	

**PLEASE LIST EACH PREGNANCY BELOW:**

NO.	DATE	WEIGHT	SEX	WEEKS PREGNANT	COMPLICATIONS	TYPE OF DELIVERY (VAG/C-SEC.)
1.						
2.						
3.						
4.						
5.						

<b>MEDICATIONS/ ALLERGIES (INCLUDE VITAMINS, HERBS, ETC.)</b>							
DRUG NAME		DOSE	DRUG NAME		DOSE	ALLERGIES (DESCRIBE REACTION)	
1.			5.			1.	
2.			6.			2.	
3.			7.			3.	
4.			8.			4.	

### 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

ILLNESSES	YES	NO	UNSURE	DETAILS (DATE/ DESCRIPTION)
ASTHMA				
LUNG DISEASE/ PNEUMONIA				
KIDNEY INFECTIONS/ STONES				
TUBERCULOSIS				
HERPES				
OTHER SEXUALLY TRANSMITTED DESEASES				
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				

ILLNESSES (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/ ILLNESSES					
DATE		INJURY/ ILLNESSES			
1.					
2.					
3.					
4.					
FAMILY HISTORY					
<b>MOTHER</b> _____ LIVING _____ DECEASED—AGE/ CAUSE OF DEATH					
<b>FATHER</b> _____ LIVING _____ DECEASED—AGE/ CAUSE OF DEATH					
<b>SIBLINGS</b> # LIVING _____ # DECEASES _____ AGES/ CAUSES OF DEATH					
<b>CHILDREN</b> # LIVING _____ # DECEASES _____ AGES/ CAUSES OF DEATH					
ILLNESS		YES	WHICH RELATIVES/ AGES OF ONSET		
DIABETES					
STROKE					
HEART DISEASE					
BLOOD CLOTS IN LEGS OR LUINGS					
HIGH BLOOD PRESSURE					
HIGH CHOLESEROL					
OSTEOPOROSIS					
HEPATITIS					
TUBERCULOSIS					

<b>ILLNESS (cont.)</b>	<b>YES</b>	<b>WHICH RELATIVES/ AGE OF ONSET</b>
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

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

	NOW	PAST	NEVER	NOTES
IRREGULAR HEARTBEAT				
<b>5. RESPIRATORY</b>	<b>NOW</b>	<b>PAST</b>	<b>NEVER</b>	<b>NOTES</b>
WHEEZING				
SPITTING UP BLOOD				
CHRONIC COUGH				
<b>6. GASTROINTESTINAL</b>	<b>NOW</b>	<b>PAST</b>	<b>NEVER</b>	<b>NOTES</b>
DIARRHEA				
BLOODY STOOL				
NAUSEA/ VOMITING				
CONSTIPATION				
INVOLUNTARY LOSS OF STOOL				
<b>7. GENITOURINARY</b>	<b>NOW</b>	<b>PAST</b>	<b>NEVER</b>	<b>NOTES</b>
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				
<b>8. MUSCULOSKELETAL</b>	<b>NOW</b>	<b>PAST</b>	<b>NEVER</b>	<b>NOTES</b>
MUSCLE WEAKNESS				
MUSCLE OR JOINT PAIN				
<b>9. SKIN</b>	<b>NOW</b>	<b>PAST</b>	<b>NEVER</b>	<b>NOTES</b>
RASH				
SORES				
DRY SKIN				

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

<b>PATIENT SIGNATURE:</b>	
<b>DATE REVIEWED BY PHYSICIAN:</b>	<b>PHYSICIAN SIGNATURE</b>
<b>ANNUAL REVIEW</b> <b>DATE:</b>	<b>PHYSICIAN SIGNATURE:</b>
<b>DATE:</b>	<b>PHYSICIAN SIGNATURE:</b>
<b>DATE:</b>	<b>PHYSICIAN SIGNATURE:</b>
<b>DATE:</b>	<b>PHYSICIAN SIGNATURE:</b>

