



NEW PATIENT MEDICAL HISTORY

Name: _____ Date form completed: _____

(NOTE: If you have not previously completed the NEW PATIENT GYNECOLOGIC HISTORY form please notify us.)

p. **MEDICAL ILLNESSES**

Do you have or have you had:

	Yes	No		Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / liver disorder	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Colitis / enteritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs / lungs / heart	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Serious injury / accident	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Recent immunization	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetic complication	<input type="checkbox"/>	<input type="checkbox"/>

q. **FAMILY HISTORY**

Living? Age or

	Yes	No	age at death	Health Problems
Mother	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>

Which of your blood relatives have:

- Cancer _____
- Diabetes _____
- Hypertension _____
- High Cholesterol _____
- Heart disease _____
- Stroke _____
- Premature menopause _____
- Endometriosis _____

r. SYSTEMIC REVIEW

Headaches: Number per week _____ Medication used _____
 mild moderate severe
 improving worsening no change
 with visual symptoms with vomiting
 stress related migraines

	Yes	No		Yes	No
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>
Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Blind spots	<input type="checkbox"/>	<input type="checkbox"/>	Urgent / frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Unable to smell	<input type="checkbox"/>	<input type="checkbox"/>	Blood / abnormal color of urine	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Unable to control urination	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal urinary tract	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Kidney x-ray	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Bladder cystoscopy	<input type="checkbox"/>	<input type="checkbox"/>
Denture / bridges	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding from gums	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>	Take aspirin/ibuprofen frequently	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Breast mass	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic changes	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Breast implants	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	Do monthly breast self-exam	<input type="checkbox"/>	<input type="checkbox"/>
TB skin test	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hair growth	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Food intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice / hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Recent stress increase	<input type="checkbox"/>	<input type="checkbox"/>	Blood in bowel movement	<input type="checkbox"/>	<input type="checkbox"/>
Recent anxiety increase	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>
Nerve / head injury	<input type="checkbox"/>	<input type="checkbox"/>	Colitis / enteritis	<input type="checkbox"/>	<input type="checkbox"/>
Sensation loss / numbness	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Muscle control / weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal liver function tests	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>
Bowel x-ray	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Bowel endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal thyroid function test	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Damp skin	<input type="checkbox"/>	<input type="checkbox"/>	Disc disease	<input type="checkbox"/>	<input type="checkbox"/>
Unusual hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Extraordinary fatigue	<input type="checkbox"/>	<input type="checkbox"/>			
Uterine fibroids (myomas)					