Nacogdoches OBSTETRICS AND GYNECOLOGY

NEW PATIENT HISTORY

Date:

PERSONAL PROFILE	
LAST NAME:	FIRST NAME:
ADDRESS:	CITY/ST/ZIP:
HOME PHONE #:	CELL PHONE #:
WORK PHONE#:	EMAIL:
DATE OF BIRTH (mm/dd/yyyy):	SOCIAL SECURITY #:
PRIMARY INSURED/GUARANTOR DIFFERENT THAN ABOVE (circle)? YES/NO RELATIONSHIP TO PATIENT (circle): Spouse/Child/Employee/Other	GUARANTOR INFORMATION (if required) Name: SSN: DOB:
EMERGENCY CONTACT NAME:	EMERGENCY CONTACT PHONE:
PRIMARY CARE PROVIDER:	MARITAL STATUS (circle): Single/Married/Divorced/Partner/Widow/ Legally Separated
PREFERRED LANGUAGE:	Spouse/Partner Name:
EMPLOYMENT STATUS (circle): Employed/Unemployed/Military/Student/ Retired	RACE (circle): African American/ White/ Hispanic/ Other:
EMPLOYER:	IF MINOR, PARENT NAME & PHONE:

MEDICATIONS		
DRUG NAME & DOSE	DRUG NAME & DOSE	DRUG NAME & DOSE
1.	4.	7.
2.	5.	8.
3.	6.	9.

GYNECOLOGIC HISTORY	
LAST PERIOD (FIRST DAY):	AGE PERIODS BEGAN:
NUMBER OF DAYS BLEEDING:	NUMBER OF DAYS BETWEEN PERIODS:
ANY RECENT CHANGES IN PERIODS?	ARE YOU SEXUALLY ACTIVE?
SEXUAL ORIENTATION (circle): Straight/L/G/T/B/Q	HAVE YOU RECEIVED GARDASIL VACCINE? Yes/No/I don't know
CURRENT BIRTH CONTROL:	LAST PAP SMEAR (year):
HISTORY OF ABNORMAL PAP? Yes / No	LAST MAMMOGRAM (year):
HISTORY OF ABNORMAL MAMMOGRAM? Yes / No	LAST COLONOSCOPY (year):

OBSTETRIC HISTORY (Please list each pregnancy below)					
YEAR	TYPE OF DELIVERY (Vaginal/Cesarean/Miscarriage)	SEX	WEIGHT	LOCATION	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					
6.					

ALLERGIES		
1.	2.	3.
SOCIAL HISTORY		
CIGARETTES: _____ NEVER _____ CURRENT _____PAST _____PACKS PER DAY _____ YEARS		
ALCOHOL: _____ NONE _____ #DRINKS PER DAY _____ #DRINKS PER WEEK		
RECREATIONAL DRUGS: _____ CURRENT _____ PAST		
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? _____ NO _____ YES		
PAST MEDICAL HISTORY		
HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (CIRCLE IF YES)		
HAIR GROWTH/ HAIR LOSS	VAGINAL DISCHARGE	PAINFUL/HEAVY PERIODS
ARTHRITIS/JOINT PROBLEMS	ASTHMA OR LUNG DISEASE	BLOOD CLOTS IN LEGS OR LUNGS
BLOOD TRANSFUSION	BOWEL PROBLEMS	CANCER
DEPRESSION/ANXIETY	DIABETES	ENDOMETRIOSIS
HEART ATTACK	HERPES	HIGH BLOOD PRESSURE
INFERTILITY	INCONTINENCE	ABSENT OR IRREGULAR PERIODS
KIDNEY INFECTIONS/STONES	LUMPS OR PAIN IN BREASTS	LUPUS
MENOPAUSE SYMPTOMS	MIGRAINES/HEADACHES	REFLUX/STOMACH ULCER
SEIZURES	SEXUALLY TRANSMITTED DISEASES	STROKE
SUBSTANCE ABUSE	THYROID DISEASE	UNEXPLAINED WEIGHT CHANGES
UTERINE FIBROIDS		
PLEASE DESCRIBE POSITIVES:		

OPERATIONS/HOSPITALIZATIONS		
PROCEDURE/REASON HOSPITALIZED:	DATE	HOSPITAL
1.		
2.		
3.		
4.		
5.		
FAMILY HISTORY		
MOTHER ____ LIVING ____ DECEASED, AGE/CAUSE OF DEATH:		
FATHER ____ LIVING ____ DECEASED, AGE/CAUSE OF DEATH:		
SIBLINGS ____ LIVING ____ DECEASED, AGE/CAUSE OF DEATH:		
CHILDREN ____ LIVING ____ DECEASED, AGE/CAUSE OF DEATH:		
HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING CONDITIONS? (CIRCLE IF YES)		
BIRTH DEFECTS	BLOOD CLOTS IN LEGS/LUNGS	BREAST CANCER
COLON CANCER	CYSTIC FIBROSIS	DOWNS SYNDROME
HEART DISEASE	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL
OVARIAN CANCER	SICKLE CELL DISEASE	STROKE
TAY SACHS DISEASE	UTERINE CANCER	
OTHER (PLEASE DESCRIBE):		
REVIEW OF SYSTEMS		
ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING BODY SYSTEMS? (CIRCLE THOSE THAT APPLY)		
GENERAL: fatigue fever weight gain weight loss		
HEAD/EARS/NOSE/THROAT: headaches sore throat decreased hearing		
BREAST: breast lumps breast tenderness nipple discharge		
HEART: chest pain irregular heartbeat		
LUNGS: shortness of breath cough wheezing		
GASTROINTESTINAL: nausea vomiting diarrhea constipation abdominal pain		
SKIN: rashes skin lesions		
NEUROLOGIC: seizures tingling numbness		
ENDOCRINE: hair loss temperature intolerance abnormal hair growth		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?		
ARE YOU HERE TODAY FOR A ROUTINE ANNUAL EXAM OR A PROBLEM? (circle)	ROUTINE ANNUAL EXAM	PROBLEM (please describe)
THANK YOU!!!		