UB|MD OBSTETRICS & GYNECOLOGY

NEW PATIENT HISTORY FORM

Name: _____ **Date of Birth**: _____ **Email**: _____

Phone Numbers: *Home* _____ *Cell* _____ *Work* _____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____ **Phone**: _____

Emergency Contact Information

Name: _____ *Relationship*: _____

Home Phone: _____ *Work Phone*: _____

Please check any and all of the reasons listed below why you came to the doctor today.
If not listed, please explain after "other".

☐ urinary frequency ☐ urinary urgency ☐ urinary leakage
☐ urinary tract infections ☐ night-time urination ☐ vaginal bulge
☐ pelvic pain ☐ discomfort with sexual activity ☐ blood in urine
☐ difficulty controlling bowels ☐ incomplete bladder or bowel emptying
☐ Other_____

When did the problem begin? _____

Obstetrical History

NUMBER		NUMBER		NUMBER	
Pregnancies	_____	Abortions	_____	Miscarriages	_____
Premature Births	_____	Term births	_____	Cesarean Section	_____

	Yes/ No	Pregnancy #
Forceps or Vacuum Deliveries		
Large tears at time of delivery		
Significant pregnancy complications not listed		

Gynecological History (Please provide information on any of the following that apply to you:)

How old were you when you had your first period? _____

Skip the next box if you are post menopausal or have had a hysterectomy

Date of last menstrual period _____ Average number of days per cycle _____
Are your periods regular? ☐ Yes ☐ No How long do they last? _____
Bleeding between periods? ☐ Yes ☐ No If yes, duration _____
Heavy periods? ☐ Yes ☐ No If yes, duration _____
Pain with periods? ☐ Yes ☐ No If yes, duration _____
Birth Control Method _____

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Gynecological History continued….

Yes	No	
☐	☐	Have your menstrual periods stopped? If yes, at what age? _____
☐	☐	Have you had a hysterectomy? If yes, ☐abdominal ☐vaginal
☐	☐	Are you on hormone replacement therapy? If yes, which one? _____
☐	☐	Do you have Endometriosis, Cysts, Fibroids, or Pelvic pain? Please circle
☐	☐	Have you ever had an abnormal pap smear? If yes, when was your last abnormal? _____
☐	☐	Are you currently sexually active?
☐	☐	If not, have you been sexually active in the past?
☐	☐	Have you ever been treated for sexually transmitted disease?
		If yes, which one(s)? ☐Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ Herpes ☐ Warts ☐ Other
☐	☐	Is your sex life satisfactory to you?
☐	☐	Do you have pain with intercourse?
☐	☐	Do you have bleeding with intercourse?

How long have you been with your current sexual partner? _____

Do you have any questions about sex that you would like to ask?

_____

Preventative health

When was your last pap smear?	_____	ever abnormal? _____
When was your last mammogram?	_____	abnormal? _____
When was your last DEXA bone density?	_____	abnormal? _____
When was your last colonoscopy?	_____	abnormal? _____

Medical History **(**check all that apply to you, **and add any other medical problems)**

☐ Heart disease (high blood pressure, heart disease)
☐ Heart Murmur
☐ High Cholesterol
☐ Stroke
☐ Kidney disease _____
☐ Diabetes : how long _____
☐ Osteoporosis
☐ Recurrent muscle or joint pain
☐ Glaucoma
☐ Breathing Problems (COPD, Asthma)
☐ Thyroid Condition
☐ Bleeding Problems or Deep Vein Thrombosis
☐ Liver Problems
☐ Back Pain
☐ Neurologic Problems Parkinson's, Multiple sclerosis)
☐ Mental Illness
☐ Cancer_____
☐ **Any other medical problems** _____

_____

_____

_____

_____

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Surgical History (Please list any operations and the approximate date)

Operation	Date	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Allergies (Please list all medication, food and environmental allergies and describe the reaction.)

Allergy	Reaction

Medications (Please list all medications, vitamins and supplements you currently take. Include the dose and how often you take each medication.)

Medication	Dose	How often	Medication	Dose	How often

Personal History (Please provide as much information as possible. If not applicable, put N/A)

What do you do for a living? _____

Who do you live with? _____

Do you drink alcohol? ☐ No | ☐ Yes, for how long? _____, how much _____ Do you smoke? (cigarettes, cigars, marijuana?) ☐ No | ☐ Yes, for how long? _____, how much _____ Have you ever smoked? ☐ No | ☒ Yes , when did you quit? _____	Do you have trouble sleeping? (not rested in AM, use of medications to sleep, frequent awakening, trouble falling asleep, trouble staying asleep) ☐ No ☐ Yes, describe _____
Life Style ☐Active ☐ Sedentary Do you exercise? ☐ No | ☐ Yes , how much? _____	Do you have a health care proxy? ☐ Yes ☐ No

Family History (Please list any chronic health problems of blood relatives, including cancer history.)

Mother _____ Deceased? ☐ Yes ☐ No

Father _____ Deceased? ☐ Yes ☐ No

Siblings _____

Children _____

Review of Systems (Please check all symptoms that have occurred in the past 6 months

UB|MD Obstetrics & Gynecology

New Patient History Form

CONSTITUTIONAL
☐ Fever
☐ Feeling poorly
☐ Recent weight change
☐ Chills
☐ Feeling tired

EYES
☐ Eye pain
☐ Itchy eyes
☐ Dry eyes
☐ Wearing glasses
☐ Vision changes
☐ Blurry vision

EAR/NOSE/THROAT
☐ Earaches
☐ Nose bleeds
☐ Sore throat
☐ Loss of hearing
☐ Sinus problems
☐ Dental problems

CARDIOVASCULAR
☐ Chest pain
☐ Heart rate is fast
☐ Palpitations
☐ Leg swelling (Edema)
☐ Heart rate is slow

RESPIRATORY
☐ Shortness of breath
☐ Cough
☐ Shortness of breath with lying flat
☐ Wheezing
☐ Sleep Apnea
☐ Shortness of breath on exertion

GASTROINTESTINAL
☐ Abdominal pain
☐ Constipation
☐ Heartburn
☐ Vomiting
☐ Diarrhea
☐ Black stool (Melena)
☐ Nausea
☐ Early feeling of fullness
☐ Maroon colored stool

URINARY
☐ Blood in urine
☐ Cloudy urine
☐ Burning with urination
☐ Odor in urine
☐ Leakage of urine

OBGYN
☐ Abnormal bleeding
☐ Vulvar/Vaginal itching
☐ Irregular menses
☐ Mid-cycle bleeding
☐ Pelvic pain
☐ Pain with menses
☐ Post coital bleeding
☐ Vaginal dryness
☐ Pain with intercourse
☐ Vulvar pain
☐ No orgasm
☐ Decreased sexual drive
☐ Vaginal odor

MUSCULOSKELETAL
☐ Arthralgia (joint pain)
☐ Joint swelling
☐ Limb pain
☐ Joint stiffness
☐ Limb swelling

INTEGUMENTARY (SKIN)
☐ Acne
☐ Itching/Skin Rash
☐ Breast pain
☐ Breast discharge
☐ Change in a mole
☐ Breast lump

NEUROLOGICAL
☐ Confused
☐ Dizziness
☐ Limb weakness
☐ Memory problems
☐ Headaches/Migraines
☐ Difficulty walking
☐ Tremor

PSYCHIATRIC
☐ Suicidal
☐ Anxiety
☐ Change in personality
☐ Sleep disturbances
☐ Depression
☐ Emotional problems

ENDOCRINE
☐ Hair loss
☐ Muscle weakness
☐ Hot flashes
☐ Deepening of the voice
☐ Dry skin
☐ Heat/Cold intolerance

HEMATOLOGY/IMMUNOLOGY
☐ Easy bleeding
☐ Swollen glands
☐ Easing bruising
☐ Seasonal Allergies
☐ Hay fever

Supplementary Medication List

(Please list all medications, vitamins and supplements you currently take.
Include the dose and how often you take each medication.)

Medication	Dose	How Often?

Notes: