UB|MD OBSTETRICS GYNECOLOGY

New Patient Intake Form

Today's Date:_____

Name: _____ Date of Birth: _____

Referring Physician: _____

Primary Care Physician: _____

Reason for Today's Visit: _____

_____

Ob/Gyn History

Last menstrual period: _____

Are your menstrual periods regular? Yes / No

Pregnancy History:

Year	Outcome of pregnancy (term, preterm, ectopic, miscarriage, abortion)	Live Birth (yes/no)	Type of Delivery (vaginal or cesarean)

Current contraception method: _____

Are you currently sexually active? Yes / No

Allergies: _____

_____

Current Medications (include all prescription, over the counter and topical medications):

Medication	Dose and Frequency	Condition

Pharmacy Name Address Telephone Number

_____

Medical History

Condition	Age at Diagnosis	Active or Resolved

Surgical History

Surgical Procedure	Year

Family History

Specific Condition (cancer, mental health problem, heart disease, Alzheimer's disease, others)	Who is Affected?

What is your current occupation/job? _____

Do you smoke? Yes / No

Review of Systems

Do you currently have any of the following symptoms?

	Yes	No
Heavy menstrual bleeding or abnormal periods		
Hot flashes, night sweats or other menopausal symptoms		
Involuntary leakage of urine or stool		
Abnormal vaginal discharge, genital itching or burning with urination		
Pelvic pain for greater than 3 months		
Weight change of greater than 10 pounds in last 3 months		
Concerns about sexual function		
Migraine headaches		
Other (specify):_____		