Women & Teens
GYNECOLOGY

New Patient History Form: Adult

Name: **Today's date:**

Age: **Date of birth:**

Referred by:

Reason for visit:

First Day of Last Menstrual Period:

Menstrual History:

Age at first menses (period): Number of days between periods:
Number of days of bleeding: Nature of flow: light, moderate, heavy.
Menstrual cramps: none, mild, moderate, severe.
Menopause: yes, no. At what age?
Have you used hormone replacement therapy, past or present? Yes, no.

Gynecologic History:

Gynecologic problems: fibroids, polyps, ovarian cysts, menstrual irregularities, infertility, endometriosis, PMS, breast disease, cancer, other:

Date of last pap smear: Results: normal, abnormal.
History of abnormal pap smears, colposcopy, or treatment of abnormal pap smears: yes, no.

Sexual History:

Sexually active in past: yes, no. In present: yes, no.
Number of current partners: Age at first intercourse
Is sexual activity with men, women, or both?
Birth control method: Prior birth control methods:
List prior sexually transmitted infections, if any:
Prior history of pelvic inflammatory disease: yes, no.
Have you had the HPV vaccine, if applicable? Yes (full series, partial series), no.

Obstetrical History

Year				
Type of delivery				
Full term/pre-term				
Gender				
Birth weight				
Miscarriage/abortion				
Complications				

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Breast History:

History of past or current breast cysts, tumors, cancer: yes, no.
History of breast biopsies, aspirations, treatments: yes, no.
Date of last mammogram, if any: Results:

Bone History:

History of osteopenia or osteoporosis: yes, no.
Last bone density scan and results, if any:

Past Medical History:

Medical conditions: heart disease, asthma, diabetes, thyroid disease, high blood pressure, elevated cholesterol, irritable bowel syndrome, inflammatory bowel disease, cancer, other:

List any hospitalizations and reasons:
Transfusions: yes, no.
Colonoscopy: yes, no. Date: Results:
Seasonal flu shot: had, need, not interested

Past Surgical History:

List all surgeries and dates:

Medications:

List all medications, dosages, and supplements:

Allergies:

List food and drug allergies and nature of reaction:

Family History:

Medical conditions: heart disease, diabetes, high blood pressure, elevated cholesterol, other.

Cancer: list type of cancer, relationship to individual.

Genetic conditions: thalassemia, muscular dystrophy, etc.

Social History:

Occupation:
Are you: married, single, in a steady relationship, divorced, separated?
Have you been exposed to domestic violence?
Substance use and quantities:
Cigarettes Alcohol Drugs
Balanced diet emphasizing whole grains, fiber, fruits, vegetables, protein? Yes, no
Exercise: regular, sometimes, rarely
Do you text or use cell phone while driving? Yes, no

Other concerns/issues: