Women & Teens
GYNECOLOGY

New Patient History Form: Adolescent

Name: **Today's Date:**

Age: **Date of birth:**

Referred by:

Reason for visit:

First Day of Last Menstrual Period:

Menstrual History:

Have periods begun? Yes, no
Age at first period: Number of days between periods:
Number of days of bleeding: Menstrual flow: light, moderate, heavy.
Menstrual cramps: none, mild, moderate, severe.

Gynecologic History:

Do you perceive your pubertal development as normal or different?
Prior history of gynecologic conditions such as Polycystic Ovary Syndrome, ovarian cysts, endometriosis, Pelvic Inflammatory Disease, other: yes, no
Prior gynecologic care or exams: yes, no When? What for?
Prior pap tests: yes, no Results: normal, abnormal.
Prior pregnancies: yes, no. If yes, resulted in miscarriage, abortion, or childbirth?

Sexual History:

Sexually active: yes, no, in the past but not currently.
Is sexual activity with men, women, or both?
Type of sexual activity: genital contact, vaginal intercourse, oral sex, anal sex.
Age at onset of sexual activity: Age at onset of sexual intercourse:
Number of current sexual partners: Total number of partners to date:
Condom use: sometimes, always, never.
Other methods of birth control used now and in the past:
Is there any history of forced sex or sexual abuse? Yes, no.
Are your parents aware of your sexual activity? Yes, no.

Immunization History:

Childhood vaccinations, including Hepatitis B: yes, no.
The HPV vaccine series: yes, no. If yes, have you completed the series of 3: yes, no.
Seasonal flu shot: yes, no.

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Past Medical History:

Childhood diseases:
Hospitalizations and reasons:
Transfusions: yes, no
Medical conditions: asthma, heart, diabetes, high blood pressure, cancer, other
History of eating disorder: yes, no.
History of mood disorder: yes, no.
Prior trauma, accidents, victim of violence: yes, no.

Past Surgical History:

Prior surgeries:

Medications:

Current medications:

Allergies:

Food, drug allergies and nature of reaction:

Family History:

Ethnic background:
History of medical conditions: heart disease, high cholesterol, diabetes, cancer.
Genetic conditions: Sickle cell disease, bleeding disorders, thalassemia, others:

Social History:

School name: Grade: Performance: Learning challenges:
Relationship with family: good, bad, OK.
Relationship with friends: good, bad, OK.
Substance use and quantity:
Cigarettes Alcohol Drugs

Habits:

Balanced diet: yes, no Dairy intake/Calcium supplements: yes, no
Do you have concerns about your weight? Yes, no
Sodas, juices, caffeinated and energy drinks: yes, no
Regular exercise and fitness: yes, no
Sleep: Average number of hours per night:
Do you regularly use seatbelts and helmets? Yes, no
Do you text or use cell phone while driving? Yes, no.
Do you drive or are you a passenger when either you or the driver is under the influence of alcohol or drugs? Yes, no.
Tattoos and body piercings: yes, no.

Concerns:

Please list any issues or concerns that you would like to discuss with Dr. Sillay.