NAPLES WOMEN'S CENTER: NEW PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Age: _____ Today's Date:_____

How did you hear about our office? Please circle: Friend/Family Online Primary Doctor Other _____

Reason for your visit today: Well Woman Exam or Problem visit: _____

WOULD YOU ACCEPT A BLOOD TRANSFUSION IN A LIFE OR DEATH SITUATION? (required): ☐ Yes ☐ No

Medical History: Have you had any of the following?

☐ Anemia	☐ Cancer _____	☐ Heart Disease/ Attack	☐ Pelvic Infections
☐ Arthritis	☐ Chickenpox	☐ High Blood Pressure	☐ Reflux/Heartburn/Ulcer
☐ Asthma/COPD	☐ Depression/Anxiety	☐ High Cholesterol	☐ Stroke
☐ Bladder Infections	☐ Diabetes	☐ Kidney Disease/Stones	☐ Thyroid Disorder
☐ Blood Clots in Lungs/Legs	☐ Epilepsy/ Seizures	☐ Liver Disease/Hepatitis ___	☐ Tuberculosis
☐ Blood Transfusion	☐ Gall Bladder Disease	☐ Migraines	☐ Other: _____

List ALL medications you are currently taking, including over-the-counter medications, vitamins, and herbal remedies:

_____ _____ _____ _____

_____ _____ _____ _____

List any allergies to medications: _____ ☐ No Known Allergies

Surgical History - List all surgeries with dates:

_____ _____

_____ _____

Obstetrical History

☐ Check here if you have **NEVER** been pregnant. **Age with first pregnancy** _____

Number of pregnancies _____ **Number of elective abortions** _____ **Number of ectopic pregnancies** _____

Number of living children _____ **Number of miscarriages** _____ **Number of stillbirths** _____

Gyn History:

Age of first period _____ If in Menopause, what age/year _____

Date of last period _____

Cycle Length: every _____ days

lasting _____ days

Periods are: ☐ Regular ☐ Irregular ☐ Painful

Flow is: ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Are you sexually active ☐ Yes ☐ No ☐ Never **New partners since last visit** ☐ Yes ☐ No

Sexual Preference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other _____

Method of Birth Cont

☐ Condoms ☐ Natural Family Planning ☐ Pills: _____ ☐ Vasectomy (Partner) ☐ Depo Provera

☐ IUD: Brand _____ Year inserted ____ ☐ Tubal/ Essure ☐ Vaginal Ring ☐ Cervical Cap

☐ Sponge ☐ Spermicide ☐ Withdrawal ☐ Other ☐ None

Have you ever had any of the following STDs?

☐ Chlamydia	☐ Hepatitis B	☐ Herpes	☐ HPV	☐ Trichomonas
☐ Gonorrhea	☐ Hepatitis C	☐ HIV	☐ Syphilis	☐ None

Name:_____ Date of Birth:_____

Date of last Pap Smear? _____ ☐ Normal ☐ Abnormal

If pap was abnormal, were any of the following performed: ☐ Colposcopy ☐ Cryosurgery ☐ LEEP/Laser/Conization

Date of last Mammogram? _____ ☐ Normal ☐ Abnormal ☐ Never had a Mammogram

Date of last Bone Density? _____ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had a Bone Density

Date of last Colonoscopy? _____ ☐ Never had a Colonoscopy

Family History:

Father's side:

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other _____

Mother's side:

☐ Breast Cancer ☐ Depression ☐ Heart Disease ☐ Ovarian Cancer ☐ Uterine Cancer
☐ Colon Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disorder ☐ Blood Clots
☐ Other _____

Social History:

Exercise	☐ Yes	☐ No	Type(s) and frequency_____					
Alcohol use	☐ Yes	☐ No	If yes, _____ drink(s) per day/week/month					
Tobacco use	☐ Yes	☐ No	If yes, _____ pack(s) per day for _____ year(s)					
Caffeine	☐ Yes	☐ No	If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week/month					
Recreational Drug use	☐ Yes	☐ No	Type(s) and frequency_____					
Emotional Abuse	☐ Yes	☐ No	If yes, are you safe now	☐ Yes	☐ No	Counseling	☐ Yes	☐ No
Physical Abuse	☐ Yes	☐ No	If yes, are you safe now	☐ Yes	☐ No	Counseling	☐ Yes	☐ No
Sexual Abuse	☐ Yes	☐ No	If yes, are you safe now	☐ Yes	☐ No	Counseling	☐ Yes	☐ No

Review of Systems - Do you have any of the following symptoms TODAY?

GENERAL:

☐ Yes ☐ No Generally healthy
☐ Yes ☐ No Recent weight gain/loss of 25 lbs.
☐ Yes ☐ No Fever
☐ Yes ☐ No Vision problems (excluding glasses)
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Hearing loss
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Chronic Cough
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Heartburn/reflux

GYNECOLOGY:

☐ Yes ☐ No Abnormal Frequent urination
☐ Yes ☐ No Burning w/ urination
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Abnormal Urinary Urgency
☐ Yes ☐ No Bladder infection
☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Abnormal vaginal discharge
☐ Yes ☐ No Irregular vaginal bleeding
☐ Yes ☐ No Pelvic pain
☐ Yes ☐ No Painful intercourse
☐ Yes ☐ No Breast lumps
☐ Yes ☐ No Breast pain
☐ yes ☐ No Back pain
☐ Yes ☐ No Depression/anxiety

(**PLEASE NOTE**: Extra charges may/will occur if both a Well Woman exam and Problem visit are discussed on the same day)

_____ _____
Patient Signature Date

_____ _____
Clinician Signature Date