# *New Patient History*



Welcome to Fulton County OB/GYN. As a new patient, please fill out the information found below to the best of your ability. Thank You!

**PATIENT NAME**_____ **BIRTHDATE**_____ **AGE**____

**MARITAL STATUS**_____ **EMPLOYER**_____

**REASON FOR VISIT TODAY**_____

**ALLERGIES**

_____

**MEDICATIONS**

_____

_____

**NON-SCRIPT, HERBALS AND SUPPLEMENTS**_____

**PREVIOUS HOPITALIZATIONS OR SURGERIES WITH DATES**

_____

_____

**PAST MEDICAL HISTORY** (PLEASE CHECK IF YOU HAVE EVER HAD ANY THE FOLLOWING)

☐ MEASLES
☐ MUMPS
☐ CHICKEN POX
☐ WHOOPING COUGH
☐ SCARLET FEVER
☐ DIPTHERIA
☐ SMALLPOX
☐ PNEUMONIA
☐ RHEUMATIC FEVER
☐ HEART DISEASE
☐ ARTHRITIS
☐ VENEREAL DISEASE

☐ ANEMIA
☐ BLADDER INFECTIONS
☐ EPILEPSY
☐ MIGRAINE HEADACHES
☐ TUBERCULOSIS
☐ DIABETES
☐ CANCER
☐ POLIO
☐ GLAUCOMA
☐ HERNIA
☐ BLOOD OR PLASMA TRANSFUSIONS

☐ BACK TROUBLE
☐ HIGH BLOOD PRESSURE
☐ LOW BLOOD PRESSURE
☐ HEMORRHOIDS
☐ ASTHMA
☐ SKIN CONDITIONS
☐ AIDS OR HIV +
☐ MONO
☐ BRONCHITIS
☐ STROKE
☐ HEPATITIS
☐ ULCER

☐ KIDNEY DISEASE
☐ THYROID DISEASE
☐ BLEEDING TENDENCY
☐ ANY OTHER DISEASE (PLEASE LIST)

_____

_____

_____

**MENSTRUAL/GYNECOLOGICAL HISTORY**

**Age of First period**____ **Date of last period (1st day)**_____ **Frequency**_____

**Do you spot between periods?**☐ Yes ☐ No **Do you have cramping with cycles?**☐ Yes ☐ No

**History Vaginal Infections-** ☐ Yeast ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Trichomonos

**Are you currently sexually active-** ☐ Yes ☐ No More than one partner- ☐ Yes ☐ No

**Does your partner have a history of any STD**- ☐ Yes ☐ No If yes, which_____

**Are you or have you ever been on birth control?** ☐ Yes ☐ No If so please list it.

_____

**If post-menopausal, are you experiencing bleeding?** ☐ Yes ☐ No

**Have you been on Hormone Replacement Therapy?** ☐ Yes ☐ No How long? _____

**DATE/RESULT OF LAST PAP**_____ **History of Abnormal Pap?** ☐ Yes ☐ No

**DATE/RESULT OF LAST MAMMOGRAM** _____

**OBSTETRICAL HISTORY**



Total # of pregnancies____ Full Term Births____ Pre- term Births____
Miscarriages____ Abortions____ Ectopic____ Multiples___ Living Children____

**Pregnancies**

Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____
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Date_____ Weeks____ Weight_____ Sex___ Type of delivery_____

**IMMUNIZATIONS**

Have you ever been immunized against the HPV virus (Gardasil)- ☐ Yes ☐ No

**FAMILY HISTORY** (please indicated yes or no and which relative)

| | **Yes** | **Who** | | | |
|---|---|---|---|---|---|
| Diabetes | ____ | _____ | Breast Cancer | ____ | _____ |
| High Blood Pressure | ____ | _____ | Ovarian Cancer | ____ | _____ |
| Stroke | ____ | _____ | Uterine Cancer | ____ | _____ |
| Heart Disease | ____ | _____ | Colon Cancer | ____ | _____ |
| | | | Other | _____ | |

**PATIENT SOCIAL HISTORY**

USE OF ALCOHOL: NEVER___ RARELY___ MODERATE___ DAILY___

USE OF TOBACCO: NEVER___ RARELY___ MODERATE___ DAILY___

Packs per day_____ Did you quit? ☐ Yes ☐ No Start_____ Stop_____

USE OF STREET DRUGS: NEVER___ RARELY___ MODERATE___ DAILY___

Have you had exposure to second hand smoke? ☐ Yes ☐ No

**OTHER HISTORY**

Do you take a calcium supplement? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

Have you ever been sexually abused? ☐ Yes ☐ No

Have you ever been emotionally or physically abuse? ☐ Yes ☐ No

**Review of Systems** (DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS)

**CARDIOVASCULAR**
☐ CHEST PAIN
☐ HEART TROUBLE
☐ PALPITATION
☐ SHORTNESS OF BREATH
☐ SWELLING OF LIMBS

**RESPIRATORY**
☐ CHRONIC COUGH
☐ SPITTING UP BLOOD
☐ ASTHMA
☐ WHEEZING

**GASTROINTESTINAL**
☐ LOSS OF APPETITE
☐ CHANGE IN BOWEL MOVEMENTS
☐ RECTAL BLEEDING
☐ NAUSEA OR VOMITING
☐ FREQUENT DIARRHEA
☐ CONSTIPATION

**GENITOURINARY**(FEMALE)
☐ FREQUENT URINATION
☐ BURNING/PAINFUL URINATION
☐ BLOOD IN URINE
☐ INCONTINENCE OR DRIBBLING
☐ KIDNEY STONES
☐ PAIN WITH PERIODS
☐ IRREGULAR PERIODS
☐ VAGINAL DISCHARGE

**EYES, EARS, NOSE, THROAT**
☐ VISION CHANGES
☐ EAR RINGING
☐ MOUTH SORES
☐ SORE THROAT

**MUSCULOSKELETAL**
☐ JOINT PAIN, STIFFNESS, OR SWELLING
☐ MUSCLE PAIN OR WEAKNESS
☐ BACK PAIN

**SKIN/BREAST**
☐ RASH OR ITCHING
☐ CHANGE IN HAIR OR NAILS
☐ VARICOSE VEINS
☐ BREAST PAIN
☐ BREAST LUMP
☐ BREAST DISCHARGE

**NEUROLOGICAL**
☐ FREQUENT HEADACHES
☐ SEIZURES
☐ LIGHT HEADED OR DIZZY
☐ PARALYSIS
☐ NUMBNESS OR TINGLING

**HEMATOLOGIC/LYMPHATIC**
☐ ANEMIA
☐ SLOW TO HEAL AFTER CUTS
☐ BLEEDING OR BRUISING
☐ HEPATITIS

***TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED CORRECTLY. IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR'S OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I ALSO AUTHORIZE THE HEALTHCARE STAFF TO PERFORM THE NECESSARY SERVICES I MAY NEED.***

▶_____ _____
***SIGNATURE OF PATIENT (PARENT/GUARDIAN/P.O.A)*** ***TODAY'S DATE***

_____ _____
**Signature** **Date**

**DO Annual Review of Systems/ History**