Reproductive Health Associates
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NEW PATIENT HISTORY

1. IDENTIFYING INFORMATION

Name: ____ DOB: _____/_____/_______ Date: _____/_____/_____

Reason for visit: ☐ Preventative/ Well-Woman exam ☐ Other:____
Age:________ Marital Status: ______________ Occupation:____
Who referred you? ____
Name of internist or family doctor:____
Name of last gynecologist:____

2. MEDICATION HISTORY

List all medications and non-prescription medication that you take with the dose and timing, including vitamins, herbs, and anti-inflammatory medications: ☐ None

DRUG	DOSE	FREQUENCY	REASON FOR MEDICATION

Do you take hormone therapy or birth control pills? Please list dose and timing: ☐ None
____
____

Allergies: List all adverse reactions or allergies you have to medications and what happened ☐ None
____
____

3. MEDICAL HISTORY ☐ None

Please list any medical problems that you have, the physician taking care of you and how they are being treated.

DATE	MEDICAL PROBLEM	MEDICATION / TREATMENT	PHYSICIAN

Check if you currently have or have ever had:

Alcohol Abuse	☐	Depression / Anxiety	☐	Kidney Stones	☐
Anesthetic reaction	☐	Drug/Substance Abuse	☐	Lupus/Autoimmune Disorder	☐
Anemia	☐	Eating Disorder	☐	Mitral Valve Prolapse	☐
Asthma	☐	Heart Disease	☐	Rheumatic Fever	☐
Bleeding Disorder	☐	Hepatitis/Jaundice	☐	Seizure Disorder	☐
Blood Clots	☐	High Blood Pressure	☐	Stomach Ulcers	☐
Cancer	☐	High Cholesterol	☐	Stroke	☐
Chronic Lung Condition	☐	Hypothyroidism	☐	Transfusion Reaction	☐
Diabetes	☐	Irritable Bowel Syndrome	☐	Tuberculosis	☐

Please explain: ____
____
____

4. SURGICAL HISTORY ☐ None

List all surgeries you have had including but not limited to breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom teeth.

DATE	OPERATION	DIAGNOSIS	HOSPITAL/ M.D.

5. GENERAL HEALTH

Date/Place of last pap smear: ☐ None ____
Date/Place of last mammogram: ☐ None ____
Date/Place of last blood work: ☐ None ____
Your Height _______feet _____inches Your weight _______lbs. Your blood type: __________________________
How much alcohol do you drink/week? ☐ None ☐ Avg. less than one daily ☐ Avg. one daily ☐ Avg. more
Do you smoke? ☐ Yes ☐ No Amount/Day ____________________ How many years? ___________________________
If you quit smoking, when did you stop? ____
Have you used marijuana or other drugs in the last 5 years? ☐ Yes ☐ No Type:_________________________
Are you currently dieting or do you have a non-traditional diet? ☐ Yes ☐ No
Please Explain: ____
____
Do you perform self-breast examinations monthly? ☐ Yes ☐ No
Have you been immunized or had the following? Hepatitis A ☐ Yes ☐ No Hepatitis B ☐ Yes ☐ No

6. GYNECOLOGIC HISTORY

Age of first menstrual cycle: _____ Date of last period:_____/_____/_____ ☐ Menopausal ☐ Hysterectomy
How frequently do you bleed? _______________________ How many days do you bleed? _____________________

What do you use to keep from getting pregnant? ☐ Nothing

☐ Abstinence ☐ Diaphragm ☐ Rhythm
☐ Birth Control Pills ☐ IUD ☐ Tubal Ligation
☐ Condoms ☐ Patch ☐ Vasectomy

Please check if you have had or currently have the following:

Abnormal Pap Smear	☐	Herpes	☐	Pelvic Adhesions	☐
Chlamydia	☐	HPV	☐	PMS	☐
Condyloma (Warts)	☐	Incontinence of Urine	☐	Recent Change in Period	☐
Cramps	☐	Laser/Freezing Cervix	☐	Recurrent Vaginitis	☐
Endometriosis	☐	Mycoplasma/Ureoplasma	☐	Syphilis	☐
Fibroids	☐	Ovarian Cyst	☐	Trichomonas	☐
Gonorrhea	☐				

Sexual History:
Are you sexually active? ☐ Yes ☐ No Do you have pain with intercourse? ☐ Yes ☐ No

Infertility History: (complete if indicated)
How long have you been trying unsuccessfully to become pregnant? _____________________________________
How long have you been trying without any form of contraception? _____________________________________

Please describe any test/diagnosis/treatments you have had performed: ________________________________
____
____
____
____
____

Pregnancy History: ☐ No Pregnancies
Number of times pregnant _____ Full term births _____ Premature births _____
Elective termination _____ Miscarriage _____ Ectopic pregnancies _____

Early pregnancy loss: Please list date and length of pregnancy with outcome (less than 20 weeks)

DATE	Miscarriage/# WEEKS	ELECTIVE ABORTION/#WEEKS	HOSPITAL/M.D.

Deliveries: Please list date and length of pregnancy with outcome (lasting more than 20 weeks)

DATE	# WEEKS	VAGINAL/C-SECTION	SEX/WEIGHT	HOSPITAL/M.D.	COMPLICATIONS

Family History: ☐ Adopted
Which of your 1st degree family members have the following:

Anesthesia Problems ________________________________
Breast Cancer ________________________________
Colon Cancer ________________________________
Diabetes ________________________________
Heart Disease ________________________________
High Blood Pressure ________________________________
Ovarian Cancer ________________________________
Other Cancer ________________________________

7. SYSTEMS REVIEW

Please check if you have had or currently have the following:

HEENT	**CURRENT**	**PAST**	**N/A**
Migraines	☐	☐	☐
Chronic Headaches	☐	☐	☐
Visual Changes	☐	☐	☐
Hearing Loss	☐	☐	☐
Dizziness	☐	☐	☐
CARDIOVASCULAR			
Chest Pain	☐	☐	☐
Chronic Cough	☐	☐	☐
Abnormal Chest X-Ray	☐	☐	☐
Leg Swelling	☐	☐	☐
Heart Murmur/Mitral Valve Prolapse	☐	☐	☐
Take Antibiotics for Dental Work	☐	☐	☐
Wheezing/Heart Palpitations	☐	☐	☐
GASTROINTESTINAL			
Chronic Abdominal Bleed	☐	☐	☐
Frequent Nausea/Vomiting	☐	☐	☐
Chronic Constipation	☐	☐	☐
Persistent Diarrhea	☐	☐	☐
Bloody Stools	☐	☐	☐
Hemorrhoids	☐	☐	☐

NEUROLOGIC	**CURRENT**	**PAST**	**N/A**
Any Neurological Disorders	☐	☐	☐
Fainting	☐	☐	☐
Numbness	☐	☐	☐
Weakness	☐	☐	☐
Head/Nerve Injury	☐	☐	☐
Anxiety/ Depression	☐	☐	☐
BREAST			
Breast Lump	☐	☐	☐
Breast Tenderness	☐	☐	☐
Breast Secretion	☐	☐	☐
Bleeding from Nipples	☐	☐	☐
Breast Implants	☐	☐	☐
URINARY			
Recurrent Urinary Tract Infections	☐	☐	☐
Blood in Urine	☐	☐	☐
Painful Urination	☐	☐	☐
Kidney Stones	☐	☐	☐
HEMATOLOGY			
Frequent Bruising	☐	☐	☐
Cuts that Do Not Stop Bleeding	☐	☐	☐
Enlarged Lymph Nodes	☐	☐	☐

Please explain:____

Patient Name: ________________________________