ADVANCED WOMEN'S OBGYN ASSOCIATES
NEW PATIENT - Health History Data

Patient name: ____ **Birth date:** ____________ **Date:** _______________

Family history of:

Diabetes	Cancer	Bleeding tendency	Kidney disease	Tuberculosis
Heart disease	Stroke	Congenital anomalies	Twins	Allergies
High Blood Pressure	Nervous illness	Alcoholism	Thrombosis/blood clots	
Other (Specify):				

Previous Pregnancies, including Miscarriages and Abortions

Date of birth	Sex (M or F)	Weight at birth	Length of pregnancy	Length of labor	Complications?

Do you have a history of any of the following conditions?

Abnormal Pap smear	Blood clots/Varicose veins	Urinary incontinence	Sickle Cell disease
Painful or Heavy periods	Stroke	Bladder infection	Diabetes
Fibroids or Uterine polyps	High blood pressure	Infection of pelvis	Thyroid disease
Gonorrhea/Chlamydia	Asthma	Kidney disorder	Infertility
Herpes	Tuberculosis	Anxiety	PMS/PMDD
HIV/AIDS	COPD/Emphysema	Acne	Headaches/Migraines
Syphilis	Hepatitis/Liver disease	Epilepsy/seizures	Blood transfusion
HPV/Venereal warts	Intestinal disorder	Emotional problems	Drug use
Cancer	Gallbladder problems	Arthritis	Alcoholism
Allergies	Blood in urine/stool	Back trouble	Hernia
Heart attack or disease	Gastric Reflux/Ulcer	Eye problems/glaucoma	Skin disorder
Rheumatic fever/Murmur	Hemorrhoids	Anemia/Iron deficiency	Other (Specify)

Do you currently have any of the following symptoms?

Weight changes	Bleeding gums	Abdominal pain	Vaginal dryness
Fatigue/Weakness	Ear problems	Constipation	Aching or painful muscles
Fever/Chills	Neck pain or mass	Diarrhea	Muscle weakness
Skin rash or itching	Chest pain	Frequent urination	Swelling of arms or legs
Skin dryness	Heart palpitations	Loss of urine when coughing	Tingling sensation
Hair loss	Fainting	Uncontrollable loss of urine	Dizziness
Excess hair growth	Varicose veins	Pain with urination	Depressed mood
Breast lump or swelling	Shortness of breath	Blood in urine	Anxiety
Breast pain	Wheezing	Abnormal vaginal discharge	Hallucinations
Discharge from nipples	Cough	Pain in vulvar area	Loss of energy
Headaches	Pain with deep breaths	Pelvic pain	Excessive energy
Visual problems	Appetite changes	Loss of sex drive	Other (Specify)
Bloody nose	Nausea / vomiting	Hot flashes/night sweats	

Patient name: ______________________________ **Birth date:** ____________ **Date:** ______________

Gynecologic information:

Periods began at age:__________ Every __________ days Menstrual flow lasts _________ days

Last normal menstrual period:____________________

Type of contraception: Birth Control Pills Tubal ligation IUD Type: __________________ Date of insertion ______________

None Diaphragm Vasectomy Other: ________________________

Have you received one or more injections of HPV Vaccine (Gardisil)? Yes No If yes, how many have you received? __________

Menstrual abnormalities: Heavy Irregular Bleeding between periods or after intercourse

Severe premenstrual symptoms: ____

Other abnormalities: ____

Do you experience pelvic pain, painful intercourse or painful periods? Yes No

If yes, please describe: ____

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Are you having any other women's health issues you would like to discuss with the physician today? Yes No

If yes, please describe: ____

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Medical/Surgical information:

Family physician: ______________________________ When was your last visit there? ___________

Last pap: _________________________ Never

Last mammogram: _________________________ Never

Last colonoscopy: _________________________ Never

Medication (including birth control): Please list name of medicine, dose and frequency of use.

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Allergies to medicines, latex, shellfish, x-ray dyes, iodine or peanuts: ______________________________

Indicate volume of: Smoking _______________________ Drinking _______________________ Drug usage _______________________

Do you ever feel unsafe or afraid of someone? ☐ Yes ☐ No

Previous hospital stays (non-surgical): ____

Previous surgeries: ____

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Reason(s) for today's visit:

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For office use only:

Physician reviewed: ____________________________________ Date: ______________________

☐ Kornstein ☐ Pliskow ☐ Dai ☐ J Ackerman ☐ R Ackerman ☐ Valdescruz FD03 MD 01 ________NEW ALL