**New Patient Information Form**

Welcome to the office! Date: \_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_ lbs / kg

In your own words, please tell us why you are coming to the office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information:**

Please tell us about each of your **PREGNANCIES** (if any), including miscarriages:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Place** | **Vaginal, C-section, miscarriage, etc** | **Complications** | **Baby weight at birth** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

When was your **last Pap test**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any **abnormal** Paps in the past? YES NO

**First day of last period**: \_\_\_\_\_\_\_\_\_\_\_

Do you get **premenstrual symptoms** (PMS)? YES NO

Do you have **cramps/pain** with your periods? YES NO Sometimes

Do you require **medication** for your periods? YES NO Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of **menopause**: \_\_\_\_

Have you used **hormone replacement** before: YES NO If so, when? \_\_\_\_\_\_\_\_\_

What are you currently using for **birth control**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tubes tied / Vasectomy

Condoms Withdrawal Natural (timed intercourse) Birth Control Pills

Patch Vaginal ring Needle (Depo-Provera) Other: \_\_\_\_\_\_\_\_\_

Please circle if you have had any of the following **infections**:

Chalamydia Gonorrhea Herpes Genital warts

HIV Hepatitis B or C Chancre Syphilis

Do you have major problems with **acne** (pimples, zits)? YES NO Just a little

Do you have major problems with facial **hair** growth? YES NO Just a little

Do you have troubles with **hot flashes** or sweats? YES NO Just a little

Do you have troubles with vaginal **dryness**? YES NO Just a little

Are you currently sexually active? YES NO Just a little

Is/Are your partner(s): Male Female Both

Do you have troubles with intercourse (sex)? YES NO Just a little

Do you experience pain with intercourse (sex)? YES NO Occasionally

Please list all **SURGERIES/OPERATIONS** you have had:

|  |  |  |
| --- | --- | --- |
| **Procedure** | **Date** | **Why** |
|  |  |  |
|  |  |  |
|  |  |  |

Please list all ongoing **MEDICAL PROBLEMS** you may have:

|  |  |  |
| --- | --- | --- |
| **Name** | **How long** | **Notes** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list all your **MEDICATIONS**:

|  |  |  |
| --- | --- | --- |
| **Name** | **Dose** | **Why you take it** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

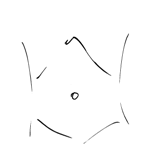
Please list all of your **ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any medical problems that run in your **FAMILY**? YES NO

Do you smoke cigarettes? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke marijuana? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY:**

**Exam**: BP: /

Abd: N Masses Scars Nodes

External: N Lesions Bx Mass LS LSC Atrophy Stenosis

Urethra: Hypermobile SUI Latent

Vagina: N Atrophy Abn Swab

Defect: Ant Gr\_\_Post Gr\_\_ Enterocele Paravag Perineal

Vault: N Atrophy Ulcer Abn Prolapse Gr 1 2 3 4 Procidentia

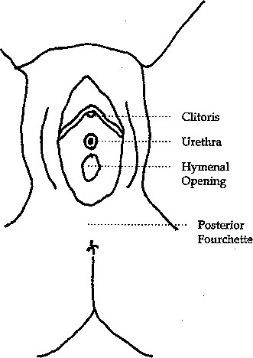
Cx: N Null Mult Prolapse Ectropion Friable Abn Pap Swab

EMB/IUD: \_\_ cm Easy/Mod/Hard/Attempted Tissue sm/mod/large

Bimanual: Ant/Mid/Retro Null/Mult/Bulky Mob/Fix Non/Tender

Ovaries: No masses; R L Bulky Fixed

Pelvirectal: N Nodular Masses IUDLot #: \_\_\_\_\_\_\_

Plan: Options: Cons Med Surg Pessary IUD Embol

Bloodwork d3 d21 semen

Ultrasound CT MRI HSG SHG Colpo

Get records from GP Specialist

Consult: Oncology Urogyn MFM REI Urology GenSurg

Rx:

Next appt: