Annual Exam/New Patient Medical History

Patient Name ______________________________ Birthdate _________ Age _____ Date ______________

Primary Care Physician ______________________________ Other Physician(s) ______________________________

Reason for Visit ____

Home Telephone ______________________________ Work Telephone ______________________________

GYNECOLOGICAL HISTORY ***Please Complete This Section***

Your age at first period?_____ Date of last period_________ Previous Period_________

How long does your period last?_____ How many pads/tampons on your worst day?_____

Are your periods regular?________ Do you bleed or spot in between periods?_________

Do you have pain with your periods?____________ Do you miss work?______________

Do you have problems with PMS?____

Are you menopausal?________ Have you had any bleeding since menopause?_________

Have you taken hormones?______ Do you have hot flashes or other symptoms?________

Have you **ever** had the following?

Acute Infections-------------	yes	no
Arthritis/Gout----------------	yes	no
Bleeding Tendency---------	yes	no
Cancer------------------------	yes	no
Convulsions------------------	yes	no
Diabetes----------------------	yes	no
Heart Trouble----------------	yes	no
Hereditary Defects----------	yes	no
Hypertension-----------------	yes	no
MRSA-------------------------	yes	no
Venereal Disease------------	yes	no
Stroke-------------------------	yes	no
Thyroid Disease-------------	yes	no

Other ______________________

Please Update Changes Since Last Annual Exam Here

What is your current method of birth control? ________________________________

Have you ever used:

Pills______ IUD______ Diaphragm______ Condoms______ Foam______

Vasectomy/tubal ligation______

Have you ever had:

Herpes______ GC______ PID______ Chlamydia______ Venereal Warts______

Does your partner have Herpes or HPV?________________

Have you ever had an abnormal Pap smear?______ If yes, what happened?_________

____

List previous hospitalizations/surgeries/serious injuries: When?

____ ______________

____ ______________

____ ______________

Monthly self breast exam?_________ Date of last mammogram____________________

Regular Exercise?____

Seat belt use?______1200mg calcium?_____ Last colon cancer screening_____________

List medications you are currently taking, including nonprescription and herbals

1____________________________
2____________________________
3____________________________
4____________________________
5____________________________
6____________________________
7____________________________
8____________________________
9____________________________
10___________________________

Do you have any **Drug Allergies**? If so, please list below:

1____________________________
2____________________________
3____________________________

Patient Social History ***Please Update Changes Since Last Annual Exam Here***

Marital Status: □ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily ______________________________

Use of Tobacco: □ Never □ Previously, but quit □ Current packs per day ______________________

Use of Drugs □ Never □ Type/Frequency ______________________________________

Excessive exposure at home or work to: □ Fumes □ Dust □ Solvents □ Noise

Review of Symptoms

Have you had any of the following during the past three months?

URINARY
Frequent Urination………… YES NO
Burning or painful urination………… YES NO
Blood in urine………… YES NO
Incontinence………… YES NO

SKIN
Rash or itching………… YES NO
Varicose Veins………… YES NO
Breast Pain………… YES NO
Breast Lump………… YES NO
Breast Discharge………… YES NO

CONSTITUTIONAL
Good general health lately………… YES NO
Recent weight change………… YES NO
Headaches………… YES NO

EYES
Wear glasses/contact lenses………… YES NO

ENT
Sinus problems………… YES NO
Sore throat or voice change………… YES NO
Swollen glands in neck………… YES NO

CARDIOVASCULAR
Heart trouble………… YES NO
Chest pains………… YES NO
Sudden heart beat changes………… YES NO
Swelling of feet, ankles, or hands………… YES NO

GASTROINTESTINAL
Loss of appetite………… YES NO
Change in bowel movements………… YES NO
Nausea or vomiting………… YES NO
Frequent diarrhea………… YES NO
Painful bowel movements or constipation………… YES NO
Blood in stool………… YES NO
Stomach Pain………… YES NO

NEUROLOGICAL
Frequent or recurring headaches………… YES NO
Light headed or dizzy………… YES NO
Numbness or tingling sensations………… YES NO

PSYCHIATRIC
Nervousness………… YES NO
Depression………… YES NO
Sleep problems………… YES NO

HEMATOLOGIC/LYMPHATIC
Easily bruise or bleed………… YES NO
Anemia………… YES NO
Phlebitis………… YES NO
Past transfusion………… YES NO

ALLERGIC
History of skin reaction or other adverse reactions to:
Penicillin or other antibiotics………… YES NO
Morphine, Demerol, or other narcotics………… YES NO
Aspirin or other pain remedies………… YES NO
Tetanus antitoxin or other serums………… YES NO
Iodine, methiolate, or other antiseptic………… YES NO

Other drugs/medications:____________________________

Known food allergies:________________________________

RESPIRATORY
Frequent coughing………… YES NO
Shortness of breath………… YES NO
Asthma or wheezing………… YES NO

ENDOCRINE
Excessive thirst or urination………… YES NO
Heat or cold intolerance………… YES NO
Dry skin………… YES NO

MUSCULOSKELETAL
Joint pain………… YES NO
Muscle pain or cramps………… YES NO
Back pain………… YES NO

Family Medical History *Please Update Changes Since Last Annual Exam Here*

☐ **Check here if there are no changes since your last visit**

	Age	Diseases	If Deceased. Cause of Death
Father			
Mother			
Siblings			
Spouse			
Grandparents			

Obstetric History *Please Update Changes Since Last Annual Exam Here*

☐ Check here if there are no changes since your last visit

List all abortions, miscarriages, tubal pregnancies:

Date	Weeks	Abortion or Miscarriage	Complications

Other pregnancies:

Date	Months Pregnant	Sex of Infant	Alive or Stillborn	Living Now	Weight at Birth	Complications

Environmental History *Please Complete This Section*

Do you have a history of abuse in your past or present? ☐ Yes ☐ No

Sexual History *Please Complete This Section*

1. Your age at first intercourse? ______
2. Number of partners (lifetime): ☐ None ☐ 1-4 ☐ 5 or more
3. Number of partners currently: ______
4. Partners: ☐ Male ☐ Female ☐ Both
5. How often do you have intercourse? ______
6. Do you have pain with intercourse? ☐ Yes ☐ No
7. Do you have orgasms? ☐ Yes ☐ No
8. Do you have any problems with sex? ☐ Yes ☐ No
9. Are you currently married? ☐ Yes ☐ No
10. Ever married? ☐ Yes ☐ No

Dietary History *Please Complete This Section Based Upon An Average Day*

1. Do you eat 3 dairy servings? _______
2. Do you eat 5 veggie/fruit servings? _______
3. How many sodas do you drink? _______
4. How many caffeinated beverages? _______
5. Do you eat a low-fat diet? _______

____

Physician Signature