Women For Women OBGYN
New Patient

Name: _____
Date of Birth: _____

Are you taking any medications? ☐ yes ☐ no

If yes, please list the medications (including over the counter medications, supplements, vitamins):

_____
_____
_____
_____
_____
_____
_____

Do you have any allergies? ☐ yes ☐ no

If yes, please list allergy and type of reaction:

_____
_____
_____
_____
_____
_____
_____

Do you have now, or have you ever had:

- ☐ Asthma
- ☐ Lung Disease
- ☐ Anemia (low blood count)
- ☐ Autoimmune disorder (Lupus, Rheumatoid Arthritis, Sjogrens)
- ☐ Bleeding Disorder
- ☐ Bone/Joint Disease
- ☐ Blood transfusion
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Leukemia/Lymphoma
- ☐ Other Cancer
- ☐ Diabetes
- ☐ Blood clots
- ☐ Depression
- ☐ Anxiety
- ☐ Elevated cholesterol
- ☐ Gastrointestinal illness
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Migraines
- ☐ Osteoporosis/Osteopenia
- ☐ Stroke/TIA
- ☐ Thyroid Disease
- ☐ Trauma
- ☐ Tuberulcosis
- ☐ Other: _____

Please mark any surgical procedure you have had:

- ☐ Dilation and curettage (D&C)
- ☐ Cesarean section
- ☐ Tubal Ligation
- ☐ Removal of an ovary
- ☐ Hysterectomy
- ☐ Breast surgery (biopsy, lumpectomy, mastectomy)
- ☐ Breast Plastic Surgery (augmentation, reduction)
- ☐ Appendectomy
- ☐ Cholecystectomy (removal of gall bladder)
- ☐ Abdominoplasty (tummy tuck)
- ☐ Hernia Repair
- ☐ Hip surgery
- ☐ Knee surgery
- ☐ Thyroid Surgery
- ☐ Spine Surgery
- ☐ Other: _____

Signature of patient: _____ Date: _____

Name: _____
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Please list any family members that have the following conditions:

Breast Cancer: _____

Colon Cancer: _____

Ovarian Cancer: _____

Uterine Cancer: _____

Other Cancer: _____

Heart Disease: _____

Heart Attack: _____

High Blood Pressure: _____

Stroke: _____

Blood clot (in arm, leg, or lung): _____

Diabetes: _____

Other disease not listed: _____

Date of last period? _____

Age at first period? _____ If menopausal, age at last period? _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

How many current sexual partners do you have? How many partners have you had in your lifetime?

Do you have sex with ☐ men ☐ women ☐ both

Have you ever had any of the following?

☐ Chlamydia ☐ Gonorrhea ☐ Pelvic Inflammatory Disease ☐ Genital Warts

☐ HPV ☐ Herpes ☐ Syphillis ☐ HIV

☐ Ovarian cysts ☐ Endometriosis ☐ Fibroids ☐ Incontinence

☐ Heavy periods ☐ Painful periods ☐ Infertility

Last Pap smear _____ Any abnormal Pap smears? ☐ yes ☐ no

Last Mammogram _____ If yes, any treatment?

Last colonoscopy _____ ☐ LEEP ☐ Cold Knife Cone

Last bone density _____ ☐ Cryo (freezing) ☐ Laser

Have you completed the HPV/Gardasil Vaccine series? ☐ yes ☐ no

Have you had the Hepatitis B vaccine series? ☐ yes ☐ no

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Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies.

Date of Delivery	Type of Delivery	# of weeks	Sex	Baby weight	Epidural?	Complications	Place of delivery

Tobacco Use: ☐ never ☐Current ____#of cigarettes per day ____#of years ☐ Former, year quit _____

Any Alcohol use? ☐ yes ☐ no If yes, average # of drinks per day? _____

Do you use recreational drugs? ☐ yes ☐ no If yes, what type and when was last use?_____

How many times per week do you exercise? _____

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? ☐ yes ☐ no

Are you safe in your current relationship? ☐ yes ☐ no

Is there a partner from a previous relationship that is making you feel unsafe now? ☐ yes ☐ no

What do you do for work? _____

Are you ☐ married ☐ single ☐ divorced ☐ separated ☐ widowed

Who do you live with? _____

If it were medically necessary, would you accept a blood transfusion? ☐ yes ☐ no

Please check any symptoms you are currently experiencing:

- ☐ Fatigue
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Fever
- ☐ Breast mass
- ☐ Breast discharge
- ☐ Easy bruising
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Nausea/Vomiting
- ☐ Leg swelling
- ☐ Frequent headaches
- ☐ Bleeding from rectum
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Leakage of urine
- ☐ Painful intercourse
- ☐ Bleeding after intercourse
- ☐ Bleeding between periods
- ☐ Vaginal itch
- ☐ Other: _____

Signature of patient: _____ Date: _____