Women For Women OBGYN
New Patient - New OB

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
☐ Abdominoplasty (tummy tuck)
☐ Hernia Repair
☐ Hip surgery
☐ Knee surgery
☐ Thyroid Surgery
☐ Spine Surgery
☐ Other: ____

Signature of patient: ______________________ Date:__________

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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? ______

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

How many current sexual partners do you have?

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 ____________

Last Mammogram ____________

Last colonoscopy ____________

Last bone density ____________

Any abnormal Pap smears? ☐ yes ☐ no

If yes, any treatment?

☐ LEEP ☐ Cold Knife Cone

☐ 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

Is this pregnancy a result of fertility treatments? ☐ yes ☐ no

Have you had the chicken pox or shingles? ☐ yes ☐ no Have you been vaccinated against the chicken pox? ☐ yes ☐ no

Have you ever been exposed to Tuberculosis? ☐ yes ☐ no

Have you ever had Parvovirus (also known as fifth disease? ☐ yes ☐ no

Is there a family or personal history of:

☐ Thalassemia?
☐ Neural Tube Defect?
☐ Congenital Heart Defect?
☐ Down Syndrome?
☐ Canavan Disease
☐ Sickle Cell Disease or Trait?

☐ Hemophilia?
☐ Muscular Dystrophy?
☐ Cystic Fibrosis?
☐ Huntington’s Disease?
☐ Mental Retardation
☐ Fragile X?

☐ BRCA
☐ Lynch Syndrome
☐ Other Genetic diseases?
☐ Previous Child with Birth Defects?
☐ more than 3 miscarriages?
☐ stillbirth?

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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:____________