

**TO EXPEDITE YOUR VISIT, PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. THIS INFORMATION HELPS THE PHYSICIAN PROVIDE YOU THE BEST CARE**

## Evaluation – New Patient

Name: \_\_\_\_\_ DOB: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

Name of Spouse/Partner: \_\_\_\_\_ Referred By: \_\_\_\_\_

Primary Physician: \_\_\_\_\_  I do not have a primary physician.

Reason for today's visit: \_\_\_\_\_

**CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:**

**CONSTITUTIONAL**

- Weight loss/weight gain Amt:
- Fatigue/Weakness
- Fever

**EYES**

- Vision problem

**HENT**

- Ringing in ears
- Hearing problem
- Headaches

**BREAST**

- Breast Lumps
- Breast Pain
- Breast Discharge / leaking Milk

**CARDIOVASCULAR**

- Chest pain
- Rapid Heart Rate
- Swelling in legs

**RESPIRATORY**

- Wheezing
- Shortness of breath
- Coughing up blood
- Cough

**GASTROINTESTINAL**

- Heartburn
- Nausea / Vomiting

- Abdominal pain
- Constipation / Diarrhea
- Bloody stools
- Persistent Bloating

**GYN**

- Not having periods
- Irregular periods
- Heavy periods
- Bleeding between periods
- Painful periods
- Pelvic pain
- Pain with intercourse
- Spotting with or after intercourse
- Decreased sex drive
- Vaginal discharge
- Vaginal dryness
- Hot flashes / night sweats

**URINARY**

- Urinary frequency
- Urinary urgency
- Difficulty starting to urinate
- Painful urination
- Blood in urine
- Leaking urine

**SKIN**

- Rash / itching

- New skin lesions
- Changes in existing lesions/moles

**NEUROLOGIC**

- Seizures
- Dizziness / Fainting/Passing out

**MUSCULOSKELETAL**

- Joint pain / swelling
- Muscle pain / weakness

**ENDOCRINE**

- Excessive urination
- Excessive thirst
- Cold intolerance
- Heat intolerance
- Loss of hair

- Changes in hair texture
- Changes in skin texture
- Excessive hair growth

**PSYCHIATRIC**

- Anxiety / depression
- Difficulty sleeping

**HEMATOLOGIC/BLOOD**

- Anemia
- Easy bleeding / bruising
- Swollen lymph nodes

**ALLERGIC**

- Sinus allergy symptoms

**PAST MEDICAL HISTORY:** (Check if you have ever had or been diagnosed with any of the following)

**EYES**

- Eye problems

**BREAST**

- Fibrocystic Breast Disease

**CARDIOVASCULAR**

- Deep Venous Thrombosis
- Heart murmur
- Heart problems
- High blood pressure
- High Cholesterol
- Rheumatic fever
- Stroke

**RESPIRATORY**

- Asthma
- Chronic Lung Disease
- Pneumonia
- Tuberculosis

**GASTROINTESTINAL**

- Bowel Troubles

- Gallbladder Problems

- Intestinal Ulcers
- Irritable Bowel Syndrome
- Yellow jaundice or hepatitis

**GYN / STDs**

- Cervical pre-cancer/Dysplasia
- Chlamydia
- Endometriosis
- Genital Warts
- Gonorrhea
- Herpes, Genital
- Infertility
- Ovarian Cysts
- Premenstrual Syndrome
- Trichomonas
- Uterine Fibroids

**URINARY**

- Infection
- Kidney Stones

**HEMATOLOGIC/BLOOD**

- Anemia
- Transfusions

**PSYCHIATRIC**

- Anxiety
- Depression
- Mental Illness

**MUSCULOSKELETAL**

- Arthritis
- Fracture/broken bone

**NEUROLOGICAL**

- Epilepsy/Seizures

**ENDOCRINE**

- Diabetes
- Thyroid Disorder

Cancer / Type: \_\_\_\_\_

Other: \_\_\_\_\_

**HEALTH SCREENINGS**

**Last Bone Density Test**

Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Last Colonoscopy**

Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Last Mammogram**

Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Last Pap Smear**

Year: \_\_\_\_\_  Prior Abnormal Pap Smear Year: \_\_\_\_\_

**ALLERGIES:** Please list all Medication /Food/Environmental Allergies and type of Reaction:

**PAST SURGICAL HISTORY:** (Please check any that you have had and indicate approximate date)

- Appendectomy \_\_\_\_\_       D&C \_\_\_\_\_       Hysterectomy \_\_\_\_\_       Tubal Ligation \_\_\_\_\_  
 Breast \_\_\_\_\_       Gallbladder \_\_\_\_\_       Ovary \_\_\_\_\_       Vaginal Repair \_\_\_\_\_  
 Cesarean section \_\_\_\_\_       Heart \_\_\_\_\_       Tonsillectomy \_\_\_\_\_  
 Other \_\_\_\_\_

**CURRENT MEDICATIONS:** List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary.

Medication	Strength	How Often	Prescribed By	Reason

**IMMUNIZATION HISTORY:** Have you received the following vaccinations?

- Hepatitis B      Date \_\_\_\_\_       HPV      Date \_\_\_\_\_  
 Influenza      Date \_\_\_\_\_       Varicella(Chicken pox)      Date \_\_\_\_\_  
 Tetanus/Tdap      Date \_\_\_\_\_       Rubella (Measles)      Date \_\_\_\_\_

**FAMILY HISTORY:** (Please check if any of your close family members have had the following)

Adopted

Condition	Relation to you	Maternal(M) Paternal (P)	Diag Age	Condition	Relation to you	Maternal (M) Paternal (P)	Diag Age
<input type="checkbox"/> Breast Cancer				<input type="checkbox"/> High Blood Pressure			
<input type="checkbox"/> Ovarian Cancer				<input type="checkbox"/> Stroke			
<input type="checkbox"/> Colon Cancer				<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> Other Cancer not mentioned:				<input type="checkbox"/> Bleeding/Blood Clot Disorder			
<input type="checkbox"/> Diabetes				<input type="checkbox"/> Depression			
<input type="checkbox"/> Heart Disease				<input type="checkbox"/> Other:			

**GYNECOLOGICAL HISTORY:** (Fill in blanks or check boxes where appropriate)

Age at first menstrual period: \_\_\_\_\_ Days between the first day of each period: \_\_\_\_\_ days      Duration of flow: \_\_\_\_\_ days

Flow:  Light  Medium  Heavy      Frequency that you change protection \_\_\_\_\_

1<sup>st</sup> Day of Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Menopausal      Age at Menopause \_\_\_\_\_       Unexpected bleeding since menopause

How do you prevent pregnancy? \_\_\_\_\_

**OBSTETRICAL HISTORY:**

Pregnancies \_\_\_\_\_ Full-Term \_\_\_\_\_ Pre-term \_\_\_\_\_ Abortions \_\_\_\_\_ Miscarriages \_\_\_\_\_ Tubal Prgnancies \_\_\_\_\_ Multiple \_\_\_\_\_ Living \_\_\_\_\_

Date	Weeks	Labor Hrs	Weight	Sex	Delivery Type	Anesthesia	Early Labor?	Complications	Location/Physician

**SOCIAL HISTORY:**

Marital Status:  Single  Married  Divorced  Widowed  Steady Relationship  Same-sex partner

Are you sexually active?  Yes  No  Plan to be sexually active in future

Education: Grade completed \_\_\_\_\_  Graduated High School  GED  Some College  Graduated College  Postgraduate

Tobacco Use  Never  Current  Former      Amount \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_

Alcohol Use  Never  Current  Former      Amount \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_

Recreation Drug Use  Never  Current  Former      Type \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_

Do you exercise regularly  None  Minimal  Moderate  Heavy  Active but no formal exercise

Do you use your seat belt?  Yes  No