

New Patient Information Form

Date: ____/____/_____

Name _____
Last First MI

Home Phone: (____) _____
Cell Phone: (____) _____
Work Phone: (____) _____

Address _____ City: _____ State ____ Zip _____

Insurance _____
Plan Group# ID#

Name of Primary Care Physician _____

Pharmacy _____ (____) _____ Allergies: _____
Name Phone

I AM HERE FOR (mark all that apply)

- Well Woman Exam
- Birth Control
- Hormonal Replacement
- Not Having Periods
- Bleeding Between Periods
- Pregnancy
- Vaginal Discharge
- Painful Periods
- Other _____

MEDICAL HISTORY

How Many:

	<i>Delivery Method</i>	<i>Year</i>	<i>Complications</i>
1 Full term (greater than 8 months) pregnancies do you have? ____	_____	_____	_____
2 Premature (less than 8 months) pregnancies do you have? ____	_____	_____	_____
3 Miscarriages, abortions or ectopic pregnancies do you have? ____	_____	_____	_____
4 Living children do you have? ____			

Last PAP Smear: ____/____/____ Result: _____ Where: _____
 Last Colonoscopy: ____/____/____ Result: _____ Where: _____
 Last Mammogram: ____/____/____ Result: _____ Where: _____
 Last Bone Density: ____/____/____ Result: _____ Where: _____

MENSTRUAL HISTORY

Age menses began: ____/____/____

First Day of Last Period: ____/____/____

Frequency

- 28-30 days
- 25-35 days

Duration

- 3-5 days
- 5-7 days

Flow

- Light
- Moderate
- Heavy

DO YOU HAVE

- Irregular Periods
- Painful Periods
- Pelvic Pain
- Painful Intercourse
- Fevers

CONTRACEPTION

- None
- Birth Control Pills
- Tubal Ligation
- Vasectomy
- Norplant

- Diaphragm
- Foam / Condoms
- IUD
- Withdrawal
- Natural Family Planning (Rhythm)

HAVE YOU

- Received Gardasil vaccine - how many injections 1, 2, 3
- Wish to receive Gardasil (If you are between 9 to 26 years of age)

Have you had any sexually transmitted disease

- Gonorrhea
- HIV
- Chlamydia
- Syphilis
- HPV
- Herpes

DO YOU

- Smoke - How long _____ How often _____
- Drink Alcohol - How long _____ How often _____
- Drugs (Marijuana, Cocaine, Prescription or other) - How long _____
How often _____

Do you wish to have Gonorrhea and Chlamydia testing with PAP smear?

LIST ALL SURGERIES AND DATES PREFORMED

LIST ANY PROBLEMS WITH ANESTHESIA

LIST ALL CURRENT MEDICATIONS (INCLUDING BIRTH CONTROL)

