



New Patient Registration and Medical History

Date: _____

Name _____ Date of Birth _____

By what name would you like to be called? _____

Referred by: _____

Please list all medications you are taking (including over the counter and herbal ones):

Please list and describe any allergies to medications that you have:

Office Use Only

Problem List:



New Patient Registration and Medical History (2)

Name _____ Date of Birth _____

Medical History: Please circle if you have had any of the following:

migraine headaches	hepatitis/jaundice	chicken pox
seizures	lupus	heart murmur/MVP
depression/mental health problems	asthma	high blood pressure
high cholesterol	diabetes	thyroid problems
kidney/bladder infection	ulcer/reflux	blood clots
cancer - non-gyn	bleeding disorders	gallbladder disease
Other medical problems _____		

Surgical History: Please circle if you have had any of the following

Appendectomy	Breast surgery/biopsy
Cholecystectomy (gallbladder)	Tonsillectomy
Other operations _____	

Family History: Please circle if anyone in your immediate family has had any of the following:

breast cancer	diabetes	birth defects
ovarian cancer	high blood pressure	twins
other cancers	heart disease	cystic fibrosis/tay sachs/sickle cell anemia
Other hereditary diseases: _____		
Are you of Jewish, Mediterranean or African American decent? _____		

Social History:

Do you smoke? _____	How much a day? _____
Do you use alcohol? _____	How much a week? _____
Have you ever used other drugs? _____	
Have you ever been abused? _____	

Are you under the care of any other doctors?

Is there anything you wish to discuss today?



New Patient Registration and Medical History (3)

Name _____ Date of Birth _____

Menstrual History:

Date of last menstrual period: _____
 Are your periods regular? _____ If so, give interval _____
 At what age did your periods begin? _____
 How long do your period last? _____
 Menstrual flow: light moderate heavy
 Cramps: mild moderate severe
 Do you have bleeding between periods? _____
 Do you have pain with intercourse? _____
 Do you have an abnormal vaginal discharge? _____

Obstetric History:

Number of times you have been pregnant _____
 Number of births _____
 Describe any birth defects _____

Pregnancies: *(please use back of form if needed)*

Date	Type of Delivery	At Term?	Baby's Weight	Sex	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Gynecological History:

Date of last PAP test: _____ Normal? _____
 Have you ever had an abnormal PAP? _____ Treatment? _____
 Date of last mammogram? _____

Please circle if you have ever had:

Endometriosis	Hysterectomy/Myomectomy	Genital warts/HPV
Uterine Fibroids	Ovarian Surgery	PID (Pelvic Infection)
Ectopic Pregnancy	Laparoscopy	Chlamydia/Gonorrhea
Infertility	D&C	Herpes
Fibrocystic breasts	DES Exposure	Group B strep
	Treatment of cervix	Hormone therapy
	(Laser, LEEP, cryo, cone biopsy)	Cancer-breast or Gyn (uterus, cervix, ovary)

Contraception: _____