Women's Health Center of Reno
GYNECOLOGY | INFERTILITY | OBSTETRICS | UROGYNECOLOGY

NEW PATIENT MEDICAL HISTORY OB/GYN	
Name:	Birth Date
Date:	Age

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL

Please check each question that applies to you. Put (?) if uncertain.

What brought you to see the doctor? (onset of symptoms, current problems, previous treatment, current treatment)

_____

_____

☐Yes ☐No Are you now in poor health or suffering from any chronic physical or mental condition?

☐Yes ☐No Have you had any x-rays taken in the past 5 years?
List type: _____

☐Yes ☐No Have you had any laboratory tests done in the past 2 years?
List type and result: _____

☐Yes ☐No Have you ever had a blood transfusion?

☐Yes ☐No Do you have any special religious convictions which might affect your treatment? If yes, explain:

_____

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY:

Date of last menstrual period: _____ Date of previous period: _____

Age at first period: _____ Menstrual flow usually lasts for a total of _____ days.

Have you missed periods without being pregnant? ..... ☐Yes ☐No

When NOT on birth control pills, are your periods: ☐Regular ☐Somewhat regular ☐Completely Irregular

The interval between first day of one period to first day of next period ranges from _____ to _____ days.

Menstrual flow usually is: ☐Scant ☐Moderate ☐Heavy ☐Excessive with clots

Are your periods usually painful? ..... ☐Yes ☐No

If painful: ☐Mild ☐Moderate ☐Severe ☐Incapacitating

Do you ever have any pain with sexual intercourse? ..... ☐Yes ☐No

Do you now or have you ever had a problem with infertility? ..... ☐Yes ☐No

If not menstruating, stopped at age _____. Any bleeding or spotting since? ..... ☐Yes ☐No

Do you have any abdominal or pelvic pain unrelated to menstruation? ..... ☐Yes ☐No

Do you have any other complaint, concern or question regarding sex? ..... ☐Yes ☐No

Do you have any vaginal or vulva irritation, heavy discharge or dryness? ..... ☐Yes ☐No

Do you frequently have a loss of urine with sneezing and coughing? ..... ☐Yes ☐No

Do you have frequent night urination, dribbling or urine or bedwetting? ..... ☐Yes ☐No

Do you have a protrusion or bulging sensation from your vagina? ..... ☐Yes ☐No

Contraception type: _____

Have you ever had an ABNORMAL Pap smear? ☐Yes ☐No Date: _____

Date of last Pap smear: _____

OBSTETRIC HISTORY:

How many pregnancies? _____

How many live births? _____

Number of still births? _____

How many prematures (less than 5 ½ lbs.) born alive? _____

What was the largest baby's weight? _____

Any serious complications with any pregnancy? Explain: _____

_____

How many miscarriages? _____

How many abortions? _____

Have all of your children been normal? ☐Yes ☐No

My blood is: ☐Rh Positive ☐Negative ☐Uncertain

How many children do you have? _____

Year oldest born: _____

Date of last delivery: _____

PERSONAL HISTORY

INFECTIOUS DISEASE: Check any of the following disease you have had.

☐ Measles	☐ Rhematic Fever	☐ Scarlet Fever	☐ Bladder or Kidney Infection
☐ German Measles (Rubella)	☐ Tuberculosis	☐ Encephalitis	☐ Venereal Disease
☐ Mumps	☐ Hepatitis	☐ Meningitis	☐ Chicken Pox
☐ Polio	☐ Pneumonia	☐ Tubal Infection	☐ Herpes

☐ Other: _____

SURGERY:

	Year		Year		Year
☐ Appendix	_____	☐ Tumor of any kind	_____	☐ Ovary	_____
☐ Gall Bladder	_____	☐ Varicose Veins	_____	☐ Tubes	_____
☐ Kidney Stones	_____	☐ Hernia	_____	☐ Uterus (Womb)	_____
☐ Tonsils	_____	☐ Hemorrhoids	_____	☐ Vagina or Bladder	_____
☐ Thyroid	_____	☐ Chest	_____	☐ Caesarean Section	_____
☐ Breast	_____	☐ Spine	_____	☐ D and C	_____

Others: _____

Have you ever been advised to have any surgical operation which has not been done before? ☐ Yes ☐ No

ILLNESSES: Check any of the following diseases you have had.

☐ Measles	☐ Blood Clots or Phlebitis	☐ Hernia	☐ HIV/AIDS
☐ Bleeding Disorder	☐ Heart Murmur	☐ Hemorrhoids	☐ Asthma
☐ Jaundice	☐ High Blood Pressure	☐ Colitis	☐ Convulsion
☐ Diabetes	☐ Ulcer	☐ Arthritis	☐ Kidney Stone
☐ Cancer	☐ Gall Bladder Trouble	☐ Bone Disease	☐ Nervous Breakdown
☐ Migraine	☐ Chronic Diarrhea	☐ Back Trouble	☐ Varicose Veins

Others: _____

Have you ever been hospitalized for any illness? ☐ Yes ☐ No

Diagnosis and Year: _____

MEDICATIONS:

	Never	Not in past year	Occasionally	Frequently	Daily	Name of Medication
Cortisone or Steroid	☐	☐	☐	☐	☐	_____
Blood Pressure Pills	☐	☐	☐	☐	☐	_____
Thyroid	☐	☐	☐	☐	☐	_____
Heart Medicine	☐	☐	☐	☐	☐	_____
Diuretic (Water) Pills	☐	☐	☐	☐	☐	_____
Tranquilizer or Nerve Pills	☐	☐	☐	☐	☐	_____
Appetite Suppressant or Pep Pills	☐	☐	☐	☐	☐	_____
Hormone Pill or "Shots"	☐	☐	☐	☐	☐	_____
Sleeping Pill	☐	☐	☐	☐	☐	_____
Asthma Medicine	☐	☐	☐	☐	☐	_____
Birth Control Pills	☐	☐	☐	☐	☐	_____

Others: _____

Are you allergic or have you had any reaction or side effects from drugs, vaccines or other agents? ☐ Yes ☐ No

☐ Aspirin ☐ Pain Medicine ☐ Penicillin ☐ Sulfa ☐ Novocaine ☐ Birth Control Pills

Other: _____

FAMILY HISTORY

	SEX		AGE (If Living)	HEALTH	IF DECEASED		Has any blood relative ever had (please check): Who?		
					AGE AT DEATH	CAUSE			
Father							Diabetes		
Mother							Tuberculosis		
Siblings		1.					High Blood Pressure		
		2.					Epilepsy		
		3.					Heart Disease		
		4.					Stroke		
		5.					Glaucoma		
Children		1.							
		2.							
		3.					Cancer Type		Who?
		4.							
		5.							

SOCIAL HISTORY

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

No. of Marriages: _____

Occupation: _____

Highest Level of Education: _____ Degrees: _____

Spouse Occupation: _____

Habits: Tobacco: ☐ Yes ☐ No

No. of packs per day: _____

No. of years: _____

Alcohol: ☐ Never

☐ Rare

☐ 3 – 5 drinks per week

☐ 6 – 10 drinks per week

☐ More than 10 drinks per week

Drugs: Now:

Names and how much: _____

_____

Past:

Names and how much: _____

_____

Name: _____ Date: _____

MEDICAL CARE

Are you currently under the care of any other physician: ☐ Yes ☐ No If yes, whom? _____

What type of treatment? _____

Were you referred to this office? ☐ Yes ☐ No If yes, by whom?

DO NOT WRITE BELOW THIS LINE

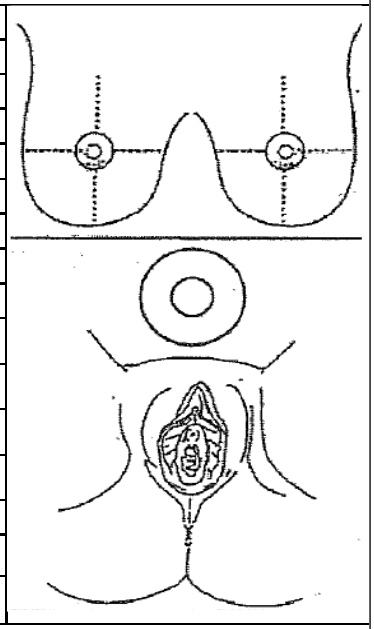
Chief Complaint

Hx by MD

Age G P SAB TAB Ectopic L.C. LMP _____/_____/_____

BP Ht Wt Urine P _____ G _____ Ni _____ Bl _____ Other_____ PMP / /

Physical Exam	General: ☐ Normal ☐ Obese ☐ Slender ☐ Other Race: W B O I H / M S W D SEP			
Neck	☐ Normal ☐ Abnormal	Thyroid ☐ Normal ☐ Abnormal		
	Nodes ☐ None ☐ Other			
Lungs	Respiratory Effort ☐ Normal ☐ Abnormal			
	Auscultation ☐ Normal ☐ Abnormal			
Breasts	☐ Normal ☐ Abnormal			
Axilla	Nodes ☐ None ☐ Other			
Heart	Rhythm ☐ Normal ☐ Abnormal	Murmur ☐ None ☐ Other		
	Gallop ☐ None ☐ Other	Peri. Vascular ☐ Normal ☐ Abnormal		
G.I.	Scars ☐ None	Hernia ☐ None		
	Liver ☐ Normal ☐ Abnormal	Spleen ☐ Normal ☐ Abnormal		
	Abdomen ☐ Normal ☐ Abnormal			
Pelvic	Ext. Genitalia ☐ Normal ☐ Abnormal	Uterus A P M ☐ Normal ☐ Abnormal		
	Urethral (meatus) ☐ Normal ☐ Abnormal	Adnexa ☐ Normal ☐ Abnormal		
	Vagina ☐ Normal ☐ Abnormal	Recto-Vaginal ☐ Normal ☐ Abnormal		
	Cervix ☐ Normal ☐ Abnormal	Stool Guaiac, if indicated ☐ Neg ☐ Pos		
Impression				



☐ Monthly SBE ☐ PAP Done ☐ Annual Mammograms ☐ Stool Guaiac x 3

☐ CA# 1000 mg/day ☐ Exercise Discussed ☐ Diet Discussed

Signature: Copy to:

Follow Up Notes:

OB-126 (8/22/07)