

LOS OLIVOS
WOMEN'S MEDICAL GROUP

OBSTETRICS - GYNECOLOGY - INFERTILITY

15151 NATIONAL AVENUE - LOS GATOS, CALIFORNIA 95032
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New Patient History

I. Identifying Information

Name: _____ Date: _____

How would you like to be contacted with test results? Mail Home Phone Cell Phone Email

Cell Phone# _____ Ok to leave results on voicemail No results on machine

Preventative/well-woman exam Reason for visit if problem: _____

Age: _____ Marital Status: _____ Occupation: _____

Who referred you? _____

Name of internist or family doctor: _____

Name of last gynecologist: _____

Partner's name: _____ Occupation: _____

Children's names: _____

Does your insurance cover preventative/well-woman exams? Yes No Unknown

List any other physicians or health care providers you see:

II: Medication History

List all medications that you take with the dose and timing: None

Drug	Dose	Frequency	Reason for medication	Prescribing MD
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Your height: _____ Your weight: _____ Your blood type: _____
How much alcohol do you drink/week? None Avg. less than 1/day Avg. 1/day Avg. more
Do you smoke? Yes No Amount/day _____ How many years _____
If you quit smoking, when did you stop? _____

Have you used marijuana or other drugs in the last 5 years? Yes No Type: _____
Are you currently dieting or do you have a non-traditional diet? Yes No

Please explain: _____

Do you perform self breast examinations monthly? Yes No

Do you have an advance directive for health care? Yes No

Have you been immunized or had the following?

Hepatitis A	<input type="checkbox"/> yes	<input type="checkbox"/> no	Hepatitis B	<input type="checkbox"/> yes	<input type="checkbox"/> no
Tetanus: Last booster greater than 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumococcus	<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> unknown
Chickenpox (Varicella)	<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> unknown	Rubella (MMR)	<input type="checkbox"/> yes	<input type="checkbox"/> no <input type="checkbox"/> unknown
Date of last TB test: _____	<input type="checkbox"/> positive	<input type="checkbox"/> negative	Last flu shot: _____		
			Guardisil	<input type="checkbox"/> yes	<input type="checkbox"/> no

VI. Gynecologic History

Date of last menstrual period: _____ Menopausal Hysterectomy

Length of cycle from first day to first day each month: _____ days Regular Irregular

Average length of each period: _____ Heavy Moderate Light

What do you use to keep from getting pregnant? Nothing Vasectomy Condoms Rhythm

Tubal ligation IUD Diaphragm Birth Control Pills Patch Abstinence

Please check if you have had the following:

Cramps	<input type="checkbox"/>	PMS	<input type="checkbox"/>	Recent change in periods	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	Fibroids	<input type="checkbox"/>	Incontinence of urine	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	Pelvic adhesions	<input type="checkbox"/>	Herpes	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>
Condyloma (warts)	<input type="checkbox"/>	Abnormal pap smear	<input type="checkbox"/>	Recurrent vaginitis	<input type="checkbox"/>
Mycoplasma/Ureoplasma	<input type="checkbox"/>	Trichomonas	<input type="checkbox"/>	HPV	<input type="checkbox"/>
Laser/Freezing of cervix	<input type="checkbox"/>				

Sexual history:

Are you sexually active? Yes No

Do you have pain with intercourse? Yes No

How many sexual partners have you had in your lifetime? _____

How many sexual partners have you had in the last year? _____

Have you ever been sexually abused or assaulted? Yes No

Are you personally concerned about AIDS? Yes No

Any sexual problems at this time? Yes No

Infertility History: (complete if indicated)

How long have you been trying unsuccessfully to become pregnant? _____

Please describe any tests/diagnosis/treatments you have performed:

Urologic History: (Complete if indicated)

Do you lose urine against your will? Yes No

Does your incontinence occur after coughing, exercising, sneezing, or lifting? Yes No

Do you have a strong sense of urgency to void just prior to losing your urine? Yes No

Do you wear a pad to protect against urine loss? Yes No

Allergies: List all adverse reactions or allergies you have to medications and what happened. None

III. Surgical History None

List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, wisdom teeth.

Date	Operation	Diagnosis	Hospital/MD
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IV. Medical History None

Please list any medical problems that you have, the physician taking care of you and how they are treated.

Date	Medical problem	Medication or treatment	Physician
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Have you had any hospitalization, injuries, fractures or motor vehicle accidents not listed elsewhere? N/A

Check if you have or have you ever had:

Alcohol abuse	<input type="checkbox"/>	Anesthetic reaction	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Chronic lung condition	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	Drug and substance abuse	<input type="checkbox"/>	Depression/anxiety	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	Lupus or autoimmune disorder	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>
Transfusion reaction	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Cancer	<input type="checkbox"/>

Please explain: _____

V. General Health

Date/place of last pap smear: None _____

Date/place of last mammogram: None _____

Date/place of last blood work None _____

Pregnancy history: No pregnancies

Number of times pregnant _____ Full term births _____ Premature births _____ Elective termination _____

Miscarriages _____ Ectopic pregnancies _____ Adopted children _____ Step children _____ Twins _____

Please list your pregnancy history:

Early pregnancy loss: List date and length of pregnancy with outcome

Date _____ Miscarriage/number of weeks _____ Elective abortion/number of weeks _____ Hospital/Doctor _____

Pregnancies lasting more than 20 weeks:

Date _____ Length of preg _____ Vaginal or _____ Sex and _____ Hospital/Doctor _____ Complications _____
in weeks _____ C-section _____ weight _____

FAMILY HISTORY: Adopted

Please Explain:

	Current age	Age at death	Health problems or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Sons	_____	_____	_____
	_____	_____	_____
Daughters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Which of your 1st degree family members have the following

Breast cancer: _____	Asthma: _____
Ovarian cancer: _____	Stroke: _____
Colon cancer: _____	High cholesterol: _____
Other cancers: _____	Bleeding disorders: _____
Diabetes: _____	Drug abuse: _____
Heart disease: _____	Drinking problem: _____
High Blood Pressure: _____	Anesthesia Problems _____

VII. SYSTEMS REVIEW: Do you have or have you had?

Please Explain:

	Current	Past	N/A		Current	Past	N/A
HEENT				BREAST			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast secretion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding from nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKIN			
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in the ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moles changing size or color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	METABOLIC			
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR				Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual loss of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing/heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Goiter (enlarged thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TESTING (list date of test if performed and where performed)			
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cystoscopy: _____			
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Heart Murmur/Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EKG: _____			
Take antibiotics for dental work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
GASTROINTESTINAL				Echocardiogram: _____			
Chronic abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Frequent nausea & vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest XRay: _____			
Lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EEG: _____			
Persistent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MRI: _____			
Black stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head _____			
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen _____			
HEMATOLOGY				_____			
Frequent bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IVP: _____			
Cuts that do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound _____			
URINARY				Gall bladder _____			
Kidney infection/Pyelonephritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen _____			
Recurrent bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvis _____			
Blood in the urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sigmoidoscopy _____			
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
NEUROLOGIC				Colonoscopy _____			
Any neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Density Test: _____			
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper GI _____			
Head or nerve injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower GI/Barium enema _____			
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Joint pain/arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endoscopy _____			
Back/disc disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			