Stanford HEALTH CARE

New Patient Health Form

Patient Name: _____ Age: _____ Last Period: _____

The following questions cover important gynecologic issues for all women. We strongly encourage everyone to have a primary care physician to cover other health issues. **Referred by: _____**

Reason for today's visit: New Patient Consultation Preoperative Visit Other (describe below)

Review of symptoms: Circle any of the following that you are **currently experiencing** ☐ **NONE**

General	Extreme Fatigue	Depression	Fever	
	Weight gain _____lbs	Weight loss _____lbs	Cold intolerance	Heat intolerance
Skin:	Rash	Change in mole		
Respiratory/Cardiac	Shortness of breath	Cough	Chest pain	Palpitations
Breast	Lump	Pain	Redness	Nipple discharge
Gastrointestinal:	Abdominal pain	Black or bloody stools	Bloating	Diarrhea
	Constipation	Nausea	Vomiting	Change in bowel movements
Gynecologic	Abnormal bleeding	Pain during sex	Vulvar lump	Painful cramps
	PMS Symptoms _____			Genital herpes
	Menopausal symptoms_____			Genital warts/HPV
	Vaginal discharge			
Urinary	Loss of urine	Pain with urination	Urinary frequency	Urgency
Musculoskeletal:	Muscle aches	Muscle weakness		
Neurologic:	Change in headaches	Numbness	Dizziness	

Drug Allergies: ☐ None ☐ Yes, List with reaction: _____

Latex allergy: ☐ YES ☐NO

Current Medications (if refill desired, check box)

Refill	Name and Dose	How are you taking it?
☐		
☐		
☐		
☐		

Preferred Pharmacy ☐Mail Order Name: _____ City: _____

Pregnancy History:

Total number of pregnancies: _ _____ Total living children: _____

Number of deliveries after 36 weeks (full term): _____ Vaginal: _____ Cesarean: _____

Number of deliveries before 36 weeks (preterm):_____ Vaginal: _____ Cesarean: _____

Number of miscarriages:_____ Number of terminations: _____ Number of ectopic pregnancies:_____

Gynecologic History:

Age Periods Began: _____ Length of Period (days): _____ Number of days between periods: _____

Do you have menstrual cramps? Yes/No

Do you have any gynecologic problems? _____

_____

Sexually Active: ☐ Yes ☐ No ☐Not Currently **Partner**: ☐Male ☐Female ☐Both

PLEASE TURN OVER AND COMPLETE BACK PAGE

Contraception or Birth Control: Abstinence Withdrawal Condom Diaphragm Foam Spermicide Sponge
Pill Ring Depo-Provera Patch
Nexplanon (inserted_____) IUD Type: _____ Inserted: (_____) Tubal Ligation Vasectomy

Medical Conditions: Circle all that apply in the past or presently

Alcohol Abuse
Alzheimer's
Anemia
Anxiety
Aortic Stenosis
Arthritis
Asthma
Atrial fibrillation
Birth Defects
Cancer _____
Chronic Obstructive Pulmonary Disease
Congestive heart failure
Coronary artery disease
Dementia
Depression
Diabetes (treated with diet/pills/insulin)
Endometriosis
Fecal Incontinence
Genital Herpes
Hepatitis B or Hepatitis C
Hypertension (high blood pressure)
Hyperlipidemia (high cholesterol)
Hyperthyroid (High thyroid)
Hypothyroid (Low thyroid)
Infertility
Irritable Bowel Syndrome
Leukemia
Myocardial Infarction (Heart attack)
Obesity
Obstructive Sleep Apnea
Osteoporosis
Polycystic Ovary Syndrome (PCOS)
Pulmonary Embolism (or blood clot)
Recurrent Bladder Infections
Renal Insufficiency or Kidney Problems
Seizure Disorder
Stroke
Tuberculosis
Ulcers or H pylori
Urinary Incontinence
Other: _____

Surgical History: please add approximate year

Abdominal Surgery Year: _____
Appendectomy Year: _____
Breast Biopsy Year: _____
Breast Implants Year: _____
Cardiac Catheterization Year: _____
Colonoscopy (polyp?) Year: _____
C-Section Year: _____
D&C for bleeding Year: _____
Gall bladder surgery Year: _____
Gastric bypass Year: _____
Heart surgery(CABG) Year: _____
Hernia Repair Year: _____
Hysterectomy Year: _____
Laparoscopy Year: _____
LEEP /cone biopsy Year: _____
Miscarriage (D&C) Year: _____
Myomectomy Year: _____
Tonsillectomy Year: _____
Tubal Ligation Year: _____
Tummy tuck Year: _____
Uterine Ablation Year: _____
Other surgery: _____

Social History:

Tobacco Use: Never smoked Current Smoker Smokeless Tobacco Ready to quit? □ Yes □ No
Packs of cigarettes each day: _____ Number of years smoked? _____
E-cigarettes: Never smoked Current Smoker Ready to quit? □ Yes □ No
Alcohol use: Do you drink alcohol? □ Yes □ No If yes, Drinks each week: _____
Recreational drug use: □ Yes □ No
Type: Marijuana Methamphetamine Ecstasy Cocaine Heroin Prescription Drug
Have you been a victim of abuse or domestic abuse? □ Yes □ No
Occupation: _____ Marital Status: _____Partner's Name: _____

Family History: Please list any medical problems that your family has had. N/A (Adopted)

Mother: _____
Father: _____
Sister: _____
Sister: _____
Brother: _____
Brother: _____
Relative-include grandparents, aunts, uncles and list maternal or paternal.
Other: _____

Screening tests: Please write when it was last performed

Pap smear: _____ Was it normal? Yes/No Where? _____
Have you ever had an abnormal Pap test? Yes/No Treatment: Colposcopy/Cryotherapy/LEEP/Cone biopsy
Colonoscopy: _____ Was it normal? Yes/No Where? _____
Mammogram: _____ Was it normal? Yes/No Where? _____
Do you do regular breast self-examinations? Yes/No
Bone Density: _____ Was it normal? Yes/No Where? _____

Vaccinations: Vaccinations can be obtained without a prescription at most pharmacies.

Influenza or flu shot: (Recommended yearly): _____
TdaP – Tetanus, Diphtheria and Pertussis or whooping cough (Recommended every 10 years) : _____
MMR: (1-2 doses if born in 1957 or later) _____
Shingles or Zoster: (Recommended after age 50) _____
Hepatitis C blood test: (Recommended once for birth between 1945-1965) _____

----------For Clinic Use Below----------

Height _____

Weight _____

Blood Pressure _____/_____

Orders: □ Pap Smear □ Mammogram □ Labs □ DXA □ STI □ GC/Chlamydia

4/30/18

Please register for chart access at https://myhealth.stanfordhealthcare.org