NEW PATIENT FORM

Name	**Date**
Occupation	Marital Status (Please circle) **Single / Dating / Engaged / Married / Divorced**
DOB (mm/dd/yyyy)	Do your religious beliefs prohibit your acceptance of blood products? **Y / N**

PAST MEDICAL HISTORY (Please circle all that apply currently or in the past)

Human Papilloma Virus (HPV)	Abnormal Pap Smear	DES Exposure	Endometriosis	Fibroids	Bacterial Vaginosis
Gonorrhea	Chlamydia	Herpes	Pelvic Inflammatory Disease (PID)	Syphilis	Tuberculosis
Breast Mass	Breast Cancer	Ovarian Cyst	Ovarian Cancer	Colon Polyp or Cancer	Cervical Cancer
Blood Clots	Migraine Headaches	Genetic Disorder	Connective Tissue Disorder	Gastric Reflux or Ulcers	IBS
High Blood Pressure	Heart Disease	High Cholesterol	Urinary Tract Infection	Kidney Disorder	Osteoporosis or Bone Fractures
Anxiety	Depression	Eating Disorder	Asthma	Diabetes	Sleep Apnea

Other: ____

If you circled any of the above, please give details including dates of diagnosis and treatments:

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PAST GYNECOLOGIC HISTORY (Date of last pap smear:_________________________**Normal / Abnormal**)

Have you ever had an abnormal pap smear?	**Y / N** If Yes, when?
Have you ever had a colposcopy?	**Y / N** If Yes, when?
Have you ever had cryotherapy, laser ablation, or a LEEP?	**Y / N** If Yes, when?

PAST SURGICAL HISTORY (Please list all past surgeries or procedures)

DATE	PROCEDURE	COMPLICATIONS

MEDICATIONS/SUPPLEMENTS (Please list all current medications and/or supplements)

MEDICATION/SUPPLEMENT	DOSE	**INDICATION** (Why are you taking this medication?)

ALLERGIES (Please list all allergies, including medications, latex and/or foods) **If none, check here: □ NKDA**

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FAMILY HISTORY (Is there a Family History of the following? Please note relationship and age of relative)

Heart Disease:	High Blood Pressure:	High Cholesterol:	Stroke:
Diabetes:	Connective Tissue Disorder:	Blood Clotting Disorder:	Cancer: (List type)
Breast Cancer:	Ovarian Cancer:	Colon Cancer:	Pancreatic Cancer:
Uterine Cancer:	Melanoma:	Depression :	Alcoholism:

BLOOM OB/GYN

NEW PATIENT FORM

Name	Date

PAST OBSTETRICAL HISTORY (Please list all previous pregnancies)

mm/dd/yyyy	NAME	SEX	DR/HOSPITAL	TYPE OF DELIVERY (Please circle)	LENGTH OF LABOR	COMPLICATIONS
		M/F		Vaginal / C-section / Vacuum / Forceps		
		M/F		Vaginal / C-section / Vacuum / Forceps		
		M/F		Vaginal / C-section / Vacuum / Forceps		
		M/F		Vaginal / C-section / Vacuum / Forceps		

Have you had any miscarriages? **Y / N** If Yes, how many?____

Have you terminated any pregnancies? **Y / N** If Yes, how many?____

MENSTRUAL HISTORY (Date of last normal period: ____)

Is your period regular?	**Y / N**
How often do you get your period?	Every____________ days (Please provide range)
How would you describe your bleeding with your cycle?	**Normal / Mild / Moderate / Heavy / Clotting**
How often do you change a pad or tampon?	Every____________hours on the heaviest day
Do you have pain with your cycle?	**Y / N**

SEXUAL HISTORY (Please circle your answer)

Are you sexually active?	**Y / N**
How do you identify your sexuality?	**Heterosexual / Homosexual / Bisexual**
Did you have a change in sexual partner in the past year?	**Y / N**
Would you like STD testing done today?	**Y / N**

CONTRACEPTION (Please circle your answer)

Are you currently using birth control?	**Y / N**
If Yes, what method?	
Would you like to discuss alternative methods today?	**Y / N**

SOCIAL HABITS (Please circle your answer)

Do you smoke cigarettes?	**Y / N** If Yes, how much per day?______________cigarettes
Do you drink alcohol?	**Y / N** If Yes, how much?
Do you use recreational drugs?	**Y / N** If Yes, which ones and how often?
Are you afraid or are you being threatened by a partner?	**Y / N**
Do you have any dietary restrictions?	**Y / N** If Yes, what diet do you follow?

PREVENTION (Please circle your answer)

Did you receive the Gardasil vaccine for HPV?	**Y / N** If Yes, did you receive all 3? **Y / N**
Do you perform self breast exams?	**Y / N** If yes, how often? **Rarely / Frequently / Monthly**
Do you exercise?	**Y / N** If Yes, what type?
Have you ever had a mammogram?	**Y / N** If Yes, when? ______________________**Normal / Abnormal**
Have you ever had a DEXA (bone) scan?	**Y / N** If Yes, when? ______________________**Normal / Abnormal**
Have you ever had a colonoscopy?	**Y / N** If Yes, when? ______________________**Normal / Abnormal**

Please circle any symptoms you may have experienced since your last doctor's appointment:

Fatigue	Fever	Change in weight	Breast lumps
Nipple discharge	Shortness of breath	Chest pain	Nausea
Vomiting	Abdominal pain	Pelvic pain	Vaginal discharge
Vaginal dryness	Burning with urination	Frequency in urination	Abnormal vaginal bleeding
Migraines	Depression	Anxiety	Rectal bleeding

Other:____

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