BLOOM OB/GYN

NEW PATIENT FORM

Name	**DOB (mm/dd/yy)**	**Date**
Occupation	Marital Status (circle): **Single / Married / Partnered / Divorced / Widowed**	

How did you find out about Bloom Ob/Gyn? _____

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

Anxiety	Depression	Inflammatory Bowel Disease
Asthma	Diabetes	Kidney Disease
Autoimmune Disease	Eating Disorder	Lung Disease
Bleeding Disorder	Endometriosis	Migraine with/without Aura
Bone Fracture	Epilepsy/Seizure	Osteopenia or Osteoporosis
Breast Mass	Gastric Reflux or Ulcer	Sleep Apnea
Blood Clot in Leg or Lung	Gallstones	Stroke
Cancer	Genetic Disorder	Thyroid Disorder
Colon Polyp	Heart Disease	Tuberculosis
Connective Tissue Disorder	High Blood Pressure	Urinary Tract Infection

Other: _____

If you circled any of the above or have been diagnosed with something not listed above, please give details including dates of diagnosis and treatments:

_____

_____

_____

Have you ever had a blood transfusion? (Please circle) **Yes / No**

If yes, please give details: _____

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

DATE	**PROCEDURE**	**COMPLICATIONS**

Have you ever had complications related to anesthesia? (Please circle) **Yes / No**

If Yes, please describe: _____

MEDICATIONS/SUPPLEMENTS (Please list all current prescribed & over-the-counter 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**

_____

_____

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

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:

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Name	**Date**

PAST GYNECOLOGIC HISTORY

When was your last pap smear?	**Date:** **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?

Have you ever been diagnosed or treated for any of the following: (Please circle all that apply currently or in the past)

Abnormal Cycles/Bleeding	Fibroids	Ovarian Cyst
Chlamydia	Frequent Urinary Tract Infection	Pain with Intercourse
DES Exposure	Frequent Vaginal Infection	Pelvic Pain
Endometriosis	Hepatitis	Pelvic Inflammatory Disease
Genital Herpes	HIV	Pelvic Floor Prolapse or Problem
Genital Warts	Human Papillomavirus	Sexual Dysfunction
Gonorrhea	Incontinence (urine)	Syphilis
	Incontinence (stool)	

Other: _____

If you circled any of the above or have been diagnosed with something not listed above, please give details including dates of diagnosis and treatments:

_____

_____

_____

MENSTRUAL HISTORY

Have you gone through menopause?	**Y / N; If yes, at what age?**
If you are still having menstrual cycles, please answer the following:	
When was your last normal period?	**Date:**
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**

Are there any concerns about your menstrual cycle that you would like to discuss with your provider today? **Yes / No**

If yes, please describe: _____

PAST OBSTETRICAL HISTORY (Please list all previous pregnancies)

mm/dd/yyyy	CHILD'S NAME	SEX	HOSPITAL	TYPE OF DELIVERY (Please circle)	INFANT BIRTH WEIGHT	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?_____

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NEW PATIENT FORM

Name	**Date**

SEXUAL HISTORY (Please circle your answer)

Are you sexually active?	**Y / N**
How do you identify your sexuality?	**Straight / Gay / Lesbian / Bisexual / Pansexual / Asexual**
What is your current gender identity?	**Female / Male / Transgender / Gender Queer** **Other, please specify: _____**
What sex were you assigned at birth?	**Female / Male / Other, please specify: _____**
What pronoun do you prefer?	**She,her,hers / He,him,his / They,them,theirs**
Did you have a change in sexual partner in the past year?	**Y / N**
Would you like STD testing done today?	**Y / N**

Are there any concerns about your sexual activity that you would like to discuss with your provider today? **Yes / No**

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?	**Never / Current _____packs/day / Former_____yrs of use**
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:_____

_____

_____

Is there any other important information not addressed above that our providers and staff should know about you?