Lynn Driver, M.D. F.A.C.O.G.
Diane Thompson George, M.D. F.A.C.O.G.
Susan Mackey, M.D. F.A.C.O.G.
Erin Yu, M.D. Board Certified OB/GYN
Eileen Cassidy, M.D. Board Certified OB/GYN
Melissa Walco, M.D. Board Eligible OB/GYN

New Patient Information Form

Name______________________________ Age _____ Date of Birth__________________ Date________________

Reason for visit: Annual Exam Problem Visit (please describe)____________________________

Please list all of your MAJOR MEDICAL ILLNESSES: **NONE**______

1. __________________________ 3. __________________________
2. __________________________ 4. __________________________

When was your last PAP SMEAR? _____________
Do you have any history of ABNORMAL PAP SMEARS? Yes No

Have you ever had a BONE DENSITY STUDY? Yes No
If YES, when was your last one? ___________________ Was it normal? YES NO

Have you ever had a MAMMOGRAM? Yes No
If YES, when was your last one? ___________________ Was it normal? YES NO

Have you ever had a COLONOSCOPY? Yes No
If YES, when was your last one? ___________________ Was it normal? YES NO

If you are over the age of 65, have you ever received a pneumonia vaccine? YES NO

Have you gone through MENOPAUSE? Yes No
If YES:

- How old were you when you stopped having periods? ___________
- Are you on any HORMONE REPLACEMENT THERAPY? Yes No
- Do you have any significant MENOPAUSAL SYMPTOMS? Yes No
  - hot flashes night sweats vaginal dryness other_________________

Are you currently SEXUALLY ACTIVE? Yes No

If YES, HOW DO YOU PREVENT PREGNANCY? ___________________________

Have you ever been diagnosed with any of the following SEXUALLY TRANSMITTED DISEASES?
HERPES – HIV/AIDS – SYPHILIS – CHLAMYDIA – GONORRHEA

Please list all of your prior SURGERIES:

	Surgery	Year		Surgery	Year
1.			5.		
2.			6.		
3.			7.		
4.			8.		

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MEDICATIONS

Please list all PRESCRIBED MEDICATIONS that you take on a regular basis:

	Medication	Dose		Medication	Dose
1.			5.		
2.			6.		
3.			7.		
4.			8.		

(If you are on more than 8 medications please review the remainder with the nurse in the exam room)

Please list all the OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS you take on a regular basis:

1. ____________ 3. ____________
2. ____________ 4. ____________

ALLERGIES

Please list all ALLERGIES TO MEDICATIONS:

	Medication	Reaction (rash, shortness of breath, etc)
1.		
2.		
3.		

Please list any SEVERE FOOD or ENVIROMENTAL ALLERGIES you have: ____________

Are you allergic to LATEX? Yes No

FAMILY HISTORY

M=Mother **F**=Father **S**=Sister **B**=Brother **MGM**= Maternal grandmother **MGF**=Maternal grandfather **PGM**=Paternal grandmother **PGF**=Paternal grandfather

1.	High blood pressure	M	F	S	B	MGM	MGF	PGM	PGF
2.	Diabetes	M	F	S	B	MGM	MGF	PGM	PGF
3.	Heart disease	M	F	S	B	MGM	MGF	PGM	PGF
4.	Breast cancer	M	F	S	B	MGM	MGF	PGM	PGF
5.	Ovarian cancer	M	F	S	B	MGM	MGF	PGM	PGF
6.	Colon cancer	M	F	S	B	MGM	MGF	PGM	PGF
7.	Thyroid disorder	M	F	S	B	MGM	MGF	PGM	PGF
8.	Osteoporosis	M	F	S	B	MGM	MGF	PGM	PGF
9.	Blood clotting disorder	M	F	S	B	MGM	MGF	PGM	PGF
10.	Deep venous thrombosis (DVT – blood clot deep in leg)	M	F	S	B	MGM	MGF	PGM	PGF
11.	Autoimmune disorders (such as lupus, rheumatoid arthritis, etc)	M	F	S	B	MGM	MGF	PGM	PGF
12.	Other____________								

At what age did you START YOUR PERIODS? ____________

If you are still having periods:

- When was your LAST MENSTRUAL PERIOD? ____________
- Are your periods REGULAR or IRREGULAR?
- How many DAYS are there BETWEEN your cycles? ____________
- How many DAYS do your periods LAST? ____________
- Are your periods – LIGHT – MODERATE – HEAVY?
- Do you frequently SPOT between periods? Yes No
- Do you pass large CLOTS with your periods? Yes No
- Describe your CRAMPS: None MILD MODERATE SEVERE

Do you drink ALCOHOL? Rarely Occasionally Daily Never
Do you smoke CIGARETTES? Occasionally Daily Never Quit
Do you use any ILLICIT SUBSTANCES? Yes No

Are you – MARRIED – SINGLE – WIDOWED – DIVORCED - SEPARATED?

Do you EXERCISE? Regularly Occasionally Never

Are you EMPLOYED outside the home? Yes No

If YES, what type of work do you do (if you are a student please include this information as well)?

Do you have any issues with DOMESTIC VIOLENCE? YES No

Have you ever been PREGNANT? Yes No

If YES:

- How many TIMES have you been pregnant? ____________
- How MANY children have you delivered? ____________
- How many LIVING CHILDREN do you have? ____________
- Have you delivered any children PREMATURELY (before 37 weeks)? Yes No
  - If YES, how many? ________
- Have you had any MISCARRIAGES? Yes No
  - If YES, how many? ____________
- Have you had any ELECTIVE ABORTIONS? Yes No
  - If YES, how many? ____________

Please circle any SIGNIFICANT SYMPTOMS you currently experience:

- CONSTITUTIONAL: weight gain – weight loss – fatigue – loss of appetite – fevers – chills – other _____
- EYES: blurred vision – eye pain – discharge from eye – other _________
- HEAD & NECK: severe headaches – sore throat – nasal discharge – nose bleeds – decreased hearing – lightheadedness – other ________
- BREAST: lumps – tenderness – nipple discharge – other _________
- CARDIOVASCULAR: chest pain – irregular heart beat – fainting spells – other _________
- RESPIRATORY: shortness of breath – cough – wheezing – other _________
- GASTROINTESTINAL: nausea – vomiting – diarrhea – constipation – heartburn – abdominal pain – blood in stools – incontinence of stools – hemorrhoids – other ___________
- GENITOURINARY: urinary frequency – pain with urination – blood in urine – urinary incontinence – difficulty urinating – vaginal discharge – pain with intercourse – bleeding with intercourse – significant PMS – other __________
- SKIN: rash – itching – acne – abnormal hair growth – other ____________
- NEURO: headaches – weakness – numbness – other ___________
- MUSCULOSKELETAL: joint pain – joint swelling – muscle weakness – muscle pain – other __________
- ENDOCRINE: increased thirst – increased urination – hair loss – heat intolerance – cold intolerance – other ____________
- PSYCHIATRIC: anxiety – depression – confusion – other ________
- HEMATOLOGIC: easy bruising – easy bleeding – lymph node enlargement – other ________
- ALLERGIC: sinus allergies – skin allergies – other_________________

I have filled out this form completely and to the best of my ability.

Signature_______________________________ Date____________________