NEW PATIENT HISTORY ACCOUNT # _____

Ladies First
Obstetrics & Gynecology of Dothan, Inc.

Date _____

Patient Name _____ Patient Age _____ Patient DOB _____/_____/_____

Marital status: ❑ Married ❑ Widowed ❑ Divorced ❑ Single

Reason for today's visit _____

GYNECOLOGIC HISTORY

How old were you when you had your first period? _____ When was your last period? _____

How many days does your cycle last? _____ How many days between each cycle? _____

Are you menopausal? ❑ YES ❑ NO At what age did you become menopausal? _____

Are you taking any hormones/bio-identical hormones? Please list _____

What contraception do you use?

❑ NuvaRing ❑ Birth Control Pills ❑ Depo Provera ❑ Contraceptive Patch ❑ Diaphragm
❑ Vasectomy ❑ Tubal Ligation ❑ Condoms ❑ Rhythm Method ❑ Other _____
❑ IUD ❑ Mirena ❑ Copper T ❑ Implanon

When was your last PAP Smear? _____ Have you ever had an abnormal PAP? _____

If Yes, what type of abnormality? _____

Have you received Gardasil injections? ❑ YES ❑ NO Are you sexually active? ❑ YES ❑ NO

What gynecologic surgeries have you had?

❑ Hysterectomy: ❑ Vaginal ❑ Abdominal
❑ Removal of Ovary: ❑ Right ❑ Left ❑ Both
❑ Bladder Tack ❑ Vaginal Repair ❑ Anterior ❑ Posterior
❑ Enterocele ❑ Mesh Placement ❑ Tubal Ligation ❑ D&C (dilation & curettage)
❑ Laparoscopy _____
❑ Other _____

Do you have any of the following?:

❑ Painful Periods ❑ Heavy Periods ❑ Bad Cramps ❑ Pelvic Pain
❑ Irregular Bleeding ❑ Pain with Sex ❑ Skipping Periods ❑ No Period for more than 6 months
❑ Night Sweats ❑ Hot Flashes ❑ Mood Swings ❑ Poor Sleep
❑ Vaginal Dryness ❑ Vaginal Discharge ❑ Bladder Infections ❑ Urinary Leakage with Exertion
❑ Urinary Leakage with Frequency and Urgency ❑ Problems with Your Current Contraception
❑ PID (pelvic inflammatory disease)

Have you ever had a sexually transmitted disease (circle)?

❑ Chlamydia ❑ Gonorrhea ❑ Hepatitis ❑ Syphillis ❑ Herpes ❑ HPV(warts) ❑ HIV ❑ Trichomonas

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OBSTETRICAL HISTORY

How many times have you been pregnant? _____ How many Deliveries? _____ How many C-Sections? _____

How many Vaginal Deliveries? _____ How many Miscarriages have you had? _____

How many abortions have you had? _____ Have you had twins or triplets? ❑ YES ❑ NO

Weight of largest baby _____

Did you have any infertility procedures? ❑ YES ❑ NO If YES, explain:_____

Did you have any pregnancy complications (circle)? ❑ Toxemia ❑ Diabetes ❑ Preterm Labor ❑ Preterm Delivery

Other complications _____

SURGICAL HISTORY

Please list any surgeries and the dates they were done.

❑ Appendectomy ❑ Gallbladder Removal ❑ Bowel Surgery ❑ Ear Surgery
❑ Eye surgery ❑ Head/Neck Surgery ❑ Brain Surgery ❑ Hip/Knee Surgery
❑ Shoulder/Arm Surgery ❑ Other Surgeries _____

MEDICAL HISTORY

Do you have any of the following (check all that apply)?

❑ High Blood Pressure ❑ Arthritis ❑ Asthma/Lung Problems
❑ Liver Problems ❑ Diabetes ❑ Colon Problems
❑ Thyroid Disease ❑ Cancer ❑ Genito/Urinary Problems
❑ Kidney Stones ❑ Heart Disease ❑ Gall Bladder Problems
❑ Reflux/Heartburn ❑ Blood Clots to the Legs or Lungs
❑ Other, please list: _____

MEDICATIONS

Please list what medications you are taking or please hand your list to the nurse upon check in so it can be scanned into the computer.

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES

Are you allergic to ANY medications?

_____ _____ _____
_____ _____ _____

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FAMILY HISTORY

Does anyone in your family have any of the following illnesses?

❑ Breast Cancer ❑ Ovarian Cancer ❑ Colon Cancer ❑ Blood Clots to the Legs or Lungs
❑ Heart Disease ❑ Thyroid Disease ❑ Cancer _____
❑ Other _____

SOCIAL HISTORY

Do You?

❑ Smoke, How much? _____

❑ Drink Alcohol, How much? _____

❑ Drink Caffeine, How much? _____

❑ Use Illicit Drugs, What type? _____ How often? _____

❑ Exercise, What type? _____ How often? _____

What kind of work do you do? _____

HEALTH MAINTENANCE

When was your last Mammogram? _____ Where? _____

When was your last Bone Density? _____ Where? _____

When was your last Colonoscopy? _____ Where? _____

PLEASE MAKE SURE YOU HAVE EMPTIED YOUR BLADDER AND LEFT A URINE SPECIMEN

FOR OFFICE USE ONLY

Age _____ G _____ P _____

Wt _____ Ht _____

BP _____ Pulse _____

Order: _____ mammogram _____ dexa

_____ colonoscopy _____ pap

NOTES: _____