

WEST RIDGE OBSTETRICS & GYNECOLOGY, LLP

CONFIDENTIAL NEW PATIENT HISTORY

Welcome to **WEST RIDGE OB/GYN**. This information is intended to help the physician with your care. Please complete **both** sides as fully as possible.

Name _____ Date _____

Best number to call you () _____ Can we leave a message? Yes / No

Birth Date _____ Age _____ Marital Status: S M Sep W D

Primary Care Doctor _____ PCP Office Location _____ Last Menstrual Period? _____

YOUR HISTORY / REVIEW OF SYSTEMS: Do you have / had any of the following issues and underline it if other doctors are treating the problem:

- | | | |
|--|--|--|
| <p>No Yes Now</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sickle cell trait or disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid problem</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do you take antibiotics for dental work?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Transfusions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood clots / bleeding disorders</p> | <p>No Yes Now</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression / Anxiety disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Psychiatric problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness or tingling of extremities</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy/seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Weight gain/loss > 10 lbs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer, Type _____</p> | <p>No Yes Now</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney problem</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach/bowel problem</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HIV exposure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Positive Tuberculosis Test</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Toxic work exposure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall bladder problem</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any other illness (please list)</p> |
|--|--|--|

FAMILY HISTORY: Were you adopted? No Yes

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF - Maternal or Paternal), Grandmother (MGM or MGF- Maternal or Paternal)

- | | | |
|--|--|---|
| <p>No Yes Who</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart attack _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle cell disease _____</p> | <p>No Yes Who</p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid disease _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Clotting disorder/bleeding disorder _____</p> | <p>No Yes Who</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast cancer _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovarian cancer _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterus/Endometrial cancer _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Colon cancer _____</p> |
|--|--|---|

MEDICATIONS

Please list all medications you are using by name and dosage (include vitamins and herbs)

ALLERGIES

Are you allergic to (circle): Latex Iodine / Shellfish
Allergies to medications: Please list drug and reaction:

Birth control _____

SURGICAL / HOSPITALIZATION HISTORY

Please list the date and type of surgery or reason for hospitalization:

Date	Type	Date	Type
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREGNANCY HISTORY

Date + Place of Pregnancies(Delivery/Loss/Termination)	Type of Delivery (Vaginal/C-section/Loss)	Complications	Sex

GYN HISTORY

Age period started _____
 Periods come every _____ days and last for _____ days
 Periods are: regular irregular --- light moderate heavy
 Are you sexually active? No Yes / Your partner is: Male Female
 Do you have now, or have you ever had problems with the following:
 No Yes Now
 Severe cramps / pain with your period
 Bleeding between periods
 Vaginal discharge/infection
 STD (sexually transmitted disease):
 syphilis gonorrhea trichomonas
 chlamydia herpes genital warts HIV
 Abnormal Pap smears
 DES exposure (did your mother take DES?)
 Abnormalities of the uterus
 Tumors / Cysts of ovaries
 Infertility
 Sexual difficulty
 Pain/bleeding with intercourse
 Bothersome loss of urine

WELLNESS / SCREENING

Date of last test/immunization: _____
 Pap smear _____
 Mammogram _____
 DXA Scan (Bone Density) _____
 Cholesterol _____
 Colonoscopy or Sigmoidoscopy _____
 Fecal Occult Blood cards _____
 Gardasil vaccine _____
 Tetanus shot _____
 Pneumonia Vaccine _____
 Rubella Immune? _____
 No Yes Do you have a health care proxy?
 No Yes Do you perform self breast exams monthly?
 No Yes Do you exercise? Type & frequency: _____

SOCIAL HISTORY

Highest year of school completed: _____ Degree _____
 Occupation _____ Employer _____
 No Yes Caffeine: Average amount /day _____
 No Yes Tobacco: If Yes, _____ packs/day for how many years _____
 No Yes Street drugs: what? _____
 No Yes Alcohol: # drinks per day (beer, wine, liquor) _____
 No Yes History of physical or sexual abuse?

TODAY'S VISIT

What concerns or problems would you like to discuss today?

Are you interested in:
 No Yes HIV (AIDS) testing?
 No Yes STD testing?
 No Yes Chaperone with exam

Patient's Signature _____ Date _____

OFFICE USE ONLY:
 I have reviewed the above and personally discussed this with the patient. MD Sign _____ Date _____