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New Patient Form

Today's Date: ____________________

Name: ____________________ Date of Birth: ____________ Age: ________

Primary Care Physician: ____________________ Phone #: ____________________

Pharmacy: ____________________ Location: ____________________

Phone #: ____________________

Menstrual History:

First day of last menstrual period ________

Number of days from the start of one period to the start of the next ______ days

Number of days that you bleed ______ days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? ______ years

Have you had bleeding or spotting since your period stopped? Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method: ____________________

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) - Gardasil Yes ☐ No ☐

Last Pap Smear ________

Last Mammogram ________

Last Bone Density (DEXA) ________

Last Colonoscopy ________

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

Abnormal Pap Smears Yes ☐ No ☐

Sexually transmitted diseases Yes ☐ No ☐

☐ Warts ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Vaginal infections ☐ Other: ____________

Fibroids Yes ☐ No ☐

Endometriosis Yes ☐ No ☐

Infertility Yes ☐ No ☐

Urinary incontinence Yes ☐ No ☐

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Obstetrical History: Please record the number of:

Pregnancies ________ Vaginal Births ________ Ectopics ________ Abortions ________
Living Children ________ C-Sections ________ Miscarriages ________

Medical History:

- ☐ Anemia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ COPD / Emphysema
- ☐ Asthma
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Mental Illness
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Migraine Headaches
- ☐ Urinary Tract Infection
- ☐ Lupus
- ☐ Arthritis
- ☐ Back Injury
- ☐ Osteoporosis
- ☐ Liver Disease / Hepatitis
- ☐ Gall Bladder Disease
- ☐ Blood clots in veins/lungs
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer

Other Cancer, specify:________________

Other Medical Problems (list all):________________

Surgical History: Please list any operations, including the year, or your age when you had it:

☐ Hysterectomy ☐ Vaginal ☐ Abdominal
☐ Ovaries removed ☐ Both ☐ Left ☐ Right
☐ Others. List: ________________

Personal History:

Occupation ________________ Marital Status ________________

Do / Did you use tobacco products? Yes ☐ No ☐ How much? ________
Do / Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? ________
Do / Did you use illicit/street drugs? Yes ☐ No ☐ Which drugs? ________
Have you ever been tested for HIV? Yes ☐ No ☐ Year and result: ________
Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes ☐ No ☐

Medications: Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications: ________________

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Family History ☐ Negative

☐ Family History of Prostate Cancer
 ☐ First Degree Relative:____________
☐ Family History of Cardiovascular Disease
 ☐ Hearth Attack ☐ Stroke
☐ Family History of Endocrine Disease
 ☐ Diabetes ☐ Hypothyroidism ☐ Delayed Puberty ☐ Reproductive Disorder
☐ Family History of Breast Cancer
☐ Family History of Ovarian Cancer
☐ Other

Exercise

How often are you physically active for 20 minutes or longer?
☐ Never ☐ 1-2x/week ☐ 3-4x/week ☐ >5x/week
Which type(s) of exercise do you do? (check all that apply)
☐ Walking ☐ Running ☐ Weights ☐ Other:
Do you have any barriers that limit your ability to safely exercise? Yes ☐ No ☐
Please check all that apply:
☐ Work ☐ Family ☐ Energy Level ☐ Medical Condition ☐ Pain ☐ Motivation ☐ Other:________________

Caffeine

Rank your caffeine intake:
☐ High ☐ Medium ☐ Low ☐ None
What do typically drink during the day?
☐ Water ☐ Juice ☐ Tea ☐ Cola ☐ Diet Cola ☐ Coffee ☐ Other:______________
How many cups/cans per day?___________

Diet

Are you dieting? Yes ☐ No ☐
If yes, are you on a physician prescribed medical diet? Yes ☐ No ☐
How many meals do you eat on an average day?
Rank your salt intake: ☐ High ☐ Medium ☐ Low
Rank your fat intake: ☐ High ☐ Medium ☐ Low

Marital Status

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: