Name: _____

MR# _____

Gulf Coast OB/GYN

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Past Medical History:

- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bartholin Abscess
- ☐ Bartholin Cyst
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Breast Nodule
- ☐ Cervical Cancer
- ☐ Cervical Dysplasia
- ☐ Cervical Polyp
- ☐ Chlamydia
- ☐ Colon Cancer
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Dysfunctional Uterine Bleeding
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Gallbladder Disease
- ☐ Genital Herpes
- ☐ GERD
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Blood
- ☐ High Cholesterol
- ☐ HIV Infection
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Painful Periods
- ☐ Seizure
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Urinary Incontinence
- ☐ Uterine Cancer
- ☐ Vaginitis

Other: _____ _____ _____

Past Surgical History:

_____ _____ _____

_____ _____ _____

Current Medications:

Name	Dose	How Often

Allergies:

Any Medication Allergies: ☐ Yes ☐ No

Drug	Reaction

Name: _____

MR# _____

Gulf Coast OB/GYN

Family History: (indicate if mother, father, sibling, grandparent, aunt or uncle)

☐ Breast Cancer	☐ Colon Cancer	☐ Fibroids	☐ Osteoporosis
☐ Clotting Disorder	☐ Cystic Fibrosis	☐ Heart Disease	☐ Ovarian Cancer
☐ Cervical Cancer	☐ Diabetes	☐ High Cholesterol	☐ Stroke
☐ Crohn's Disease	☐ Endometriosis	☐ High Blood Pressure	☐ Uterine Cancer

Other: _____ _____ _____

Reproductive History:

Menstrual History:

Date of last period: _____ Age at first cycle: _____

How long does your cycle last: _____

Do you use tampons or pads or both: _____

Is the flow light or heavy: _____

Pregancy History:

How many pregnancies: _____ How many children: _____

Have you had an abortion: ☐ Yes ☐ No Have you ever had a miscarriage: ☐ Yes ☐ No

Have you had multiples: ☐ Yes ☐ No What type of birth control is used: _____

Social History:

Substance Use:

Alcohol: ☐ Current ☐ Former ☐ Never Amount: _____ How Long: _____

Illicit Substance Use: ☐ Current ☐ Former ☐ Never Amount: _____ How Long: _____

Type: _____

Tobacco: ☐ Current ☐ Former ☐ Never Amount: _____ How long? _____

Occupation: _____

Marital Status:

☐ Divorced ☐ Married ☐ Significant Other ☐ Single ☐ Widowed

Review of Systems:

General: ☐ Fatigue ☐ Fever

Breasts ☐ Lumps ☐ Nipple Discharge ☐ Redness ☐ Soreness ☐ Tenderness

Cardiovascular: ☐ Chest Pain

Respiratory: ☐ Shortness of Breath

Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea

Genitourinary: ☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Nausea

Skin: ☐ New Skin Lesions ☐ Rash

Neurologic: ☐ Muscular Weakness

Musculoskeletal: ☐ Muscle Cramps

Endocrine: ☐ Hot Flashes ☐ Excessive Thirst ☐ Excessive Urination

Psychiatric: ☐ Anxiety ☐ Depression