

Name: _____

DOB: _____

MR# _____

Gulf Coast OB/GYN

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Past Medical History:

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

Other: _____

Past Surgical History:

Current Medications:

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Any Medication Allergies: Yes No

Drug	Reaction
_____	_____
_____	_____

Name: _____

DOB: _____

MR# _____

Gulf Coast OB/GYN

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

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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: _____

Pregnancy 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