New Patient History and Physical

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Comments (Office Use Only)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_ HPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for today’s visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menstrual History \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Age of first period\_\_\_\_\_\_ Date of Last Period\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of days between start of one period and the next\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of days of flow\_\_\_\_ Are periods regular? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of flow Light/Medium/Heavy Are periods painful/crampy? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have bleeding between periods? Yes/No After intercourse? Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecology History** (Circle all problems in your past or present history) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Pap Date\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_ Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Venereal Warts/ Condyloma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pelvic Inflammatory Disease Chlamydia Gonorrhea Syphilis Herpes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurrent Vaginal Infections Recurrent Bladder Infections Urinary Leakage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovarian Cysts Endometriosis Fibroid Uterus Infertility PCOS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PMS: Depression/Anxiety Fluid Retention Breast Soreness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopausal Symptoms: Hot Flashes Night Sweats Vaginal Dryness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Active Yes/No Sexual Problems: Decreased Sex Drive Painful Sex \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Problems: History of Cancer Discharge Abnormal Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Past Biopsy: Date\_\_\_\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Implants Reduction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Control Method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** (Check all problems in your past or present history) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chicken Pox \_\_\_ Chronic Lung Disease \_\_\_ Tuberculosis \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma \_\_\_ Heart Disease \_\_\_ Hypertension \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol \_\_\_ Migraines \_\_\_ Seizures \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke \_\_\_ Hepatitis/Jaundice \_\_\_ Ulcers/Reflux \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Stones \_\_\_ Diabetes \_\_\_ IBS \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease \_\_\_ Anemia \_\_\_ Thyroid Disease \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Accident \_\_\_ Glaucoma \_\_\_ Blood Transfusion \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_ Depression/Anxiety \_\_\_ Osteoporosis \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems** (Office Use Only)

**Constitutional**: Weight Loss, Weight Gain, Fevers, Fatigue **Musculoskeletal**: Muscle Weakness, Joint Pains, Low Back Pain

**Eyes**: Contacts/Glasses, Double Vision, Spots Before Eyes, Tunnel Vision **Skin/Breast**: Breast Pain, Discharge, Masses, Rash, Ulcers, Acne

**ENT**: Ear Aches/ Ringing, Sinus Problems, Sore Throat/Mouth, Dental Problems **Neurological**: Dizziness, Seizure, Numbness, Trouble Walking

**CV**: Palpitations, Chest Pain, Difficulty Breathing, Leg Swelling **Psychiatric**: Depression, Crying, PMS, Sleep Disorder, Eating Disorder

**Respiratory**: Wheezing, Spitting up Blood, Shortness of Breath, Chronic Cough **Endocrine**: Dry Skin, Abnormal Thirst, Hair Loss, Facial Hair

**GI**: Diarrhea, Nausea/Vomiting, Constipation, Hemorrhoids, Incontinence **Hematologic/Lymphatic**: Bruising, Enlarged Lymph Nodes, Bleeding

**Urinary**: Blood, Pain, Urgency, Frequency, Incontinence, Incomplete Emptying **Allergy/Immunologic**: Environmental, Food, Immune Disorder

**New Patient History and Physical**

**Obstetrical History**

Please fill out completely regardless of stage of life, including live births, still births, miscarriages, abortions, and tubal pregnancies.

Date Pregnancy Length Labor Duration Sex Weight Delivery Type

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**Surgical History Medications** (Including Vitamins) **Allergies** (Medication/Type of Reaction)

 Year Procedure Medication Dosage

\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History Screening Tests/Vaccines** (List most recent date)

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap Smear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Marital Status: Single/Married/Widow/Divorced Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Sexual Preference: Heterosexual/Homosexual/Bisexual Cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Do you Exercise? Yes/No Type/Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Do you Smoke? Yes/No Number per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EKG/Stress Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Do you drink Alcohol? Yes/No Number per week\_\_\_\_\_\_\_ Bone Density Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Do you use Recreational Drugs? Yes/No Type\_\_\_\_\_\_\_\_\_ TB Skin Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Do you wear your seatbelt in the car? Yes/No Rubella Immunity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal/Abnormal

Do you have problems with Verbal/Physical Abuse? Yes/No Flu Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow a special diet? Yes/No Type\_\_\_\_\_\_\_\_\_\_\_\_ Pneumonia Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History** Gardasil Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate which family members have the following conditions, past or present.

Ovarian Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Melanoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uterine Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colon Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mom: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive/Deceased Age\_\_\_\_\_ Cancer/Heart Disease?

Dad: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive/Deceased Age\_\_\_\_\_ Cancer/Heart Disease?

Siblings: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive/Deceased Age\_\_\_\_\_ Cancer/Heart Disease?

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive/Deceased Age\_\_\_\_\_ Cancer/Heart Disease?

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive/Deceased Age\_\_\_\_\_ Cancer/Heart Disease?

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alive/Deceased Age\_\_\_\_\_ Cancer/Heart Disease?

 **Please list any additional issues or comments you would like to address.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_