TriHealth
Women's Services
Associates in Ob-Gyn

MEDICAL HISTORY (NEW PATIENT)

PATIENT NAME:______________________________ BIRTH DATE:__________ AGE:_____ VISIT DATE:__________________

Reason for visit: Are you currently having any problems? If yes, explain:_________________________________

____

____

Do you have drug allergies? ❏ No ❏ Yes, specify: ____

Are you sexually active? ❏ No ❏ Yes With? ❏ Men ❏ Women How many sexual partners within the last year?______________

Are you menopausal? ❏ No ❏ Yes; year of last menstrual period: Age ____ or year of hysterectomy: ____________________ (SKIP TO NEXT SECTION)

How often does your period start? Every_______days How long?_______days How many pads/tampons do you use on the heaviest days?__________

What type of birth control, if any, are you using? ❏ NONE ❏ I would like to discuss options today ❏ Condoms/Spermicide ❏ Vasectomy

❏ Tubal Ligation or implants ❏ Birth Control Pills / Patch / Ring (Name) ________________________________ ❏ DepoProvera

❏ IUD: Mirena or Paraguard, year of insertion_______ ❏ Implanon, year of insertion_______ ❏ Natural Family Planning (Rhythm) ❏ Diaphragm

Date of your last period: ___________/__________/__________Are your periods regular? ❏ Yes ❏ No Age of onset of menstrual cycles ___________

NEXT SECTION

Last PAP smear: ❏ never ❏ month/year ________/________ Ever had an abnormal pap smear? ❏ No ❏ Yes, describe ____________________

Last mammogram: ❏ never ❏ month/year ________/________ Ever had an abnormal mammogram? ❏ No ❏ Yes, describe ________________

Last DEXA scan: ❏ never ❏ month/year________/________ Ever had an abnormal D E X A? ❏ No ❏ Yes, describe ____________________

Do you smoke cigarettes? ❏ No ❏ Yes How many cigarettes/day? _______________

Do you drink alcohol? ❏ No ❏ Occasional ❏ Yes How much per day? _______________

Do you use street drugs? ❏ No ❏ Yes Please describe ____

Any medical problems or hospitalizations that have occurred in the past year or since your last visit?: ❏ NONE

Explain:____

____

____

____

____

SYSTEMS REVIEW: Check if you are experiencing any of the following complaints:

General:
❏ Excessive Fatigue /Weakness
❏ Unexplained weight loss or gain
❏ Abnormal Thirst
❏ Changes in sleep patterns
❏ Unexplained Fever

Heart/Lung:
❏ Persistent Cough
❏ Shortness of Breath
❏ Severe Chest Pain
❏ Recurrent Heart flutters

Extremities:
❏ Arthritis/Joint Pain
❏ Persistently swollen ankles
❏ Recurrent Leg Cramps

Neurologic:
❏ Fainting Spells
❏ Convulsions
❏ Dizzy Spells
❏ Frequent Severe Headaches
❏ Depression or Anxiety
❏ Vision changes

Intestinal:
❏ Gall Bladder Trouble
❏ Bloody Stools
❏ Loss of Appetite
❏ Change in Bowel Habits
❏ Constipation or Diarrhea
❏ Nausea or Vomiting
❏ Persistent Pain in Abdomen

Head and neck:
❏ Unusual Skin Moles
❏ Persistent Swollen Glands
❏ Pain or Stiff Neck
❏ Goiter or Lump in neck

Urinary:
❏ Uncontrolled Loss of Urine
❏ Blood or Pus in the Urine
❏ Kidney or Bladder Infections
❏ Frequent Urination at Night

Breast:
❏ Discharge
❏ Bothersome Pain
❏ Lump in Breast
❏ Lump under arm

Gynecologic:
❏ Clots or heavy flow with periods
❏ Miss regular activity on periods
❏ Bleeding between periods
❏ Significant pain with periods
❏ Sexual Problems
❏ Unusual vaginal discharge
❏ Significant Pelvic Pain
❏ Bothersome PMS
❏ Bothersome Menopause symptoms

❏ Other

❏ NONE OF THESE

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NEW PATIENT SUPPLEMENTAL MEDICAL HISTORY

List any current medical problems for which you see a doctor: (i.e. High Blood Pressure, High Cholesterol, Asthma, Stroke, Heart Attack, DVT, Thyroid disorder)

❏ NONE

1.______________________ 4.______________________

2.______________________ 5.______________________

3.______________________ 6.______________________

PREGNANCY HISTORY ❏ NONE

DATE MONTH/YR.	LABOR LENGTH	TYPE OF DELIVERY/PLACE OF DELIVERY CESAREAN/VAGINAL/MISCARRIAGE/ABORTION	ANESTHESIA	INFANT NAME	SEX	WEIGHT	COMPLICATIONS

CURRENT MEDICATIONS (list dosage and frequency) ❏ NONE

NAME OF MEDICATION	DOSAGE	FREQUENCY

SURGICAL PROCEDURES/HOSPITALIZATIONS ❏ NONE

DATE	PROCEDURE/REASON FOR ADMISSION	HOSPITAL	COMPLICATIONS

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NEW PATIENT SUPPLEMENTAL MEDICAL HISTORY

PERSONAL/SOCIAL HISTORY

Marital Status ______________________ Occupation ______________________

Religion ______________________

Have you ever been treated for the following sexually transmitted diseases?

❏ Syphilis ❏ Gonorrhea ❏ Chlamydia ❏ Herpes ❏ Hepatitis B ❏ Genital Warts / HPV ❏ HIV ❏ NONE

If yes, when and how was it treated? ______________________

Have you ever had endometriosis/uterine fibroids/pelvic inflammatory disease or other gynecological problems? ❏ Yes ❏ No

Please describe any problems and treatment ______________________

FAMILY HISTORY

Indicate your family medical history of the following:

Diabetes	❏ No	❏ Yes, what relative(s)?______	
Stroke	❏ No	❏ Yes, what relative(s)?______	
Heart Disease	❏ No	❏ Yes, what relative(s)?______	
High Blood Pressure	❏ No	❏ Yes, what relative(s)?______	
Breast Cancer	❏ No	❏ Yes, what relative(s)?______	what age(s)?______
Colon Cancer	❏ No	❏ Yes, what relative(s)?______	what age(s)?______
Ovarian Cancer	❏ No	❏ Yes, what relative(s)?______	what age(s)?______
Melanoma	❏ No	❏ Yes, what relative(s)?______	what age(s)?______
Blood Clots/DVT	❏ No	❏ Yes, what relative(s)?______	what age(s)?______
Endometriosis	❏ No	❏ Yes, what relative(s)?______	
Thyroid Disorder	❏ No	❏ Yes, what relative(s)?______	
Mental Illness	❏ No	❏ Yes, what relative(s)?______	
Substance Abuse	❏ No	❏ Yes, what relative(s)?______	

Other inherited disorders:______________ ❏ No ❏ Yes, what relative(s)?______________

STOP HERE

CARE PROVIDER NOTES:______________________

HPI: (Location; Quality; Severity, Duration; Timing; Context: ❏ Brief = 1–3 ❏ Extended = 4+ or status of 3+ chronic/inactive conditions)