Lee Gynecology

New Patient History Form

Today's Date:

Name: **Date of Birth:**

Past Surgical History/Major Events:

Surgery/Major Events	Date	Notes

Ongoing Medical Problems:

Allergies:

Drug, Food and Environmental Allergies	Reaction

Medications:

Medication	Dosage

Family Health History:

Medical conditions: heart disease diabetes high blood pressure elevated cholesterol

genetic conditions other:

Cancer:

Type of Cancer	Relationship to Individual	Age at Diagnosis

Social History:

Occupation: Employer:

Are you: married single in a steady relationship divorced separated

Substance use and quantities:

cigarettes: alcohol: drugs:

Nutrition History:

Balanced diet emphasizing whole grains, fiber, fruits, vegetables, protein? yes no

Exercise: regular sometimes rarely

Developmental History

Menstrual History:

First day of last menstrual period:

Age at first menses (period): Number of days between periods:

Number of days of bleeding: Nature of flow: light moderate heavy

Menstrual cramps: none mild moderate severe

Menopause: yes no

Have you used hormone replacement therapy, past or present? yes no

Gynecologic History:

Gynecologic problems: fibroids polyps ovarian cysts breast disease

infertility endometriosis PMS cancer menstrual irregularities

other:

Date of last pap smear: Results: normal abnormal

History of abnormal pap smears, calposcopy, or treatment of abnormal pap smears? yes no

Breast History:

History of past or current breast cysts, tumors, cancer: yes no

History of breast biopsies, aspirations, treatments: yes no

Date & location of last mammogram: Results:

Bone History:

History of fractures? yes no

Date & location of last bone density scan: Results:

Sexual History:

Sexually active in past: yes no At present: yes no

Number of current partners: Age at first intercourse:

Sexual activity with: men women both

Birth control method: Prior birth control methods:

List prior sexually transmitted infections, if any:

Prior history of pelvic inflammatory disease? yes no

Have you had the HPV vaccine, if applicable? yes (full series partial series) no

Obstetrical History:

Year			
Type of delivery			
Full term/Pre-term			
Gender			
Birth weight			
Miscarriage/abortion			
Complications			

Other Concerns/Issues: