fleur
WOMEN'S HEALTH

New Patient Obstetrics & Gynecology Form

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Location: _____

Phone #: _____

Menstrual History:

First day of last menstrual period..... _____

Number of days from the start of one period to the start of the next..... _____ days

Number of days that you bleed..... _____ days

Describe the amount of menstrual flow (circle one).....light / moderate / heavy / clots

Describe the amount of menstrual discomfort (circle one).....none / mild / moderate / severe

Do you bleed in between your periods?.....Yes ☐ No ☐

Do you bleed after intercourse?.....Yes ☐ No ☐

If you stopped menstruating, at what age did you stop?..... _____

Have you had bleeding or spotting since your period stopped?.....Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method: _____

Have you ever been sexually active (had intercourse)?.....Yes ☐ No ☐

Do you experience pain or discomfort with sexual intercourse?.....Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) - Gardasil.....Yes ☐ No ☐

Last Pap Smear..... _____

Last Mammogram..... _____

Last Bone Density (DEXA) ..... _____

Last Colonoscopy..... _____

Have you ever been on hormone therapy (estrogen / progesterone)? .....Yes ☐ No ☐

Any personal history of:

Abnormal Pap Smears.....Yes ☐ No ☐

Sexually transmitted diseases.....Yes ☐ No ☐

☐ Warts ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ Vaginal infections ☐ Other: _____

Fibroids.....Yes ☐ No ☐

Endometriosis.....Yes ☐ No ☐

Infertility..... Yes ☐ No ☐

Urinary incontinence.....Yes ☐ No ☐

fleur
WOMEN'S HEALTH

Obstetrical History: Please record the number of:

Pregnancies....._____ Vaginal Births....._____ Ectopics....._____ Abortions....._____
Living Children....._____ C-Sections....._____ Miscarriages....._____

Medical History:

Anemia..... ☐
High Blood Pressure..... ☐
High Cholesterol..... ☐
Heart Disease..... ☐
Stroke..... ☐
Diabetes..... ☐
COPD / Emphysema..... ☐
Asthma..... ☐
Seizures..... ☐
Thyroid problems..... ☐

Mental Illness..... ☐
Depression..... ☐
Anxiety..... ☐
Eating disorder..... ☐
Migraine Headaches..... ☐
Urinary Tract Infection..... ☐
Lupus..... ☐
Arthritis..... ☐
Back Injury..... ☐
Osteoporosis..... ☐

Liver Disease / Hepatitis..... ☐
Gall Bladder Disease..... ☐
Blood clots in veins/lungs..... ☐
Blood Transfusion..... ☐
Breast Cancer..... ☐
Colon Cancer..... ☐
Uterine Cancer..... ☐
Ovarian Cancer..... ☐
Other Cancer, specify:_____

Other Medical Problems (list all):_____

Surgical History: Please list any operations, including the year, or your age when you had it:

☐ Hysterectomy ☐ Vaginal ☐ Abdominal
☐ Ovaries removed ☐ Both ☐ Left ☐ Right
☐ Others. List: _____

Personal History:

Occupation _____ Marital Status _____
Do / Did you use tobacco products?.....Yes ☐ No ☐ How much? _____
Do / Did you drink alcohol?.....Yes ☐ No ☐ How many drinks per week? _____
Do / Did you use illicit/street drugs?..... Yes ☐ No ☐ Which drugs? _____
Have you ever been tested for HIV?.....Yes ☐ No ☐ Year and result: _____
Have you ever been a victim of physical, verbal, emotional or sexual abuse?.....Yes ☐ No ☐

Medications: Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications: _____

fleur
WOMEN'S HEALTH

Current Medical Concerns: Please check if you have had any of the following recently:

Low-T	Yes	No
Weight gain	○	○
Fatigue	○	○
Decreased sex drive	○	○
Loss of muscle tone	○	○
Poor muscle gain	○	○
Decreased exercise Endurance	○	○

Hypothyroidism	Yes	No
Difficulty losing weight	○	○
Coarse dry skin	○	○
Hair loss	○	○
Muscle cramps and aches	○	○
Feeling cold	○	○
Adrenal fatigue	○	○
Insomnia	○	○
Day time exhaustion - Lack of energy	○	○
Anxiety - Anger - Frustration	○	○
Unexplained weight gain no matter what you try	○	○
Reliance on stimulants to Function	○	○

Leaky Gut	Yes	No
Chronic Diarrhea	○	○
Constipation	○	○
Bloating	○	○
Skin rashes	○	○
Acne	○	○
Rosacea	○	○
Eczema	○	○
Arthritis or joint pain	○	○
Craving for sugar	○	○
Food sensitivities	○	○
Headaches	○	○

Obesity	Yes	No
Increased sweating	○	○
Snoring	○	○
Low confidence and low self esteem	○	○
Feeling tired	○	○
Back and joint pains	○	○

How did you hear about us? _____

Is there any other information you feel we should have? _____

_____

_____

_____ _____

Patient Signature Date Provider Signature Date

fleur
WOMEN'S HEALTH

Prenatal Genetic Screening (FOR PREGNANT PATIENT ONLY)

Note: Fill out only if you are pregnant or planning to be pregnant in the near future.

Have you or the baby's father or anyone in your families ever had any of the following:

☐ Down Syndrome? If yes, who?_____

☐ Other Chromosomal abnormality? If yes, specify._____

☐ Neural tube defect (spina bifida, anencephaly)? If yes, who?_____

☐ Hemophilia or other coagulation abnormality? If yes, who?_____

☐ Muscular Dystrophy? If yes, who?_____

☐ Cystic Fibrosis? If yes, who?_____

If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

Yes ☐ No ☐

If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?

Yes ☐ No ☐

If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia?

Yes ☐ No ☐

If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia?

Yes ☐ No ☐

None ☐

_____ _____ _____

Patient Signature Date Time

_____ _____ _____

Physician Signature Date Time