Banner Health®

NEW PATIENT MEDICAL HISTORY
GYNECOLOGY

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

How did you hear about us? Circle all that apply. Yahoo / Google / Facebook / Health Grades / Pandora /

Other: _____

Preferred Pharmacy (name and location): _____

What is the primary reason for your visit? _____

Do you have advance directive? _____

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

List any medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**	**Refill needed (Y/N)?**

List any Vitamins, Supplements and Over the Counter Medicines

1.	**4.**
2.	**5.**
3.	**6.**

VACCINES

List the last date given:

Chicken Pox (disease or vaccine):	Pertussis (Whooping Cough):
Flu:	Pneumonia:
Hepatitis A:	Shingles:
Hepatitis B:	Tdap (Tetanus):
HPV:	

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DIAGNOSTIC TESTS

Enter last completion date and whether the result was normal.

TEST:	DATE:	NORMAL (Y/N):	TEST:	DATE:	NORMAL (Y/N):
Bone Density:			Mammogram		
Colonoscopy:			Pap Smear		

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	Date of Onset		Date of Onset		Date of Onset		Date of Onset
Abnormal Pap Smear		Depression		High Cholesterol		Preterm Delivery	
Anemia		DES Exposure		Hypertension		Psychiatric History	
Asthma		Diabetes		Incompetent Cervix		Pulmonary Embolism	
Autoimmune Disease		Drug/Alcohol Addiction		Infertility		Recurrent Miscarriages	
Bartholin's Gland Cyst		Endometriosis		Neonatal Death in the Past		Seizures	
Blood Transfusion		Family Genetic History		Phlebitis or Varicose Veins		Tuberculosis	
Breast Cancer		Fetal Death in the Past		Obesity		Uterine Cancer	
Breast Mass		Fibroid Uterus		Ovarian Cancer		UTIs Recurrent	
Bleeding Disorder		Gallbladder Disease		Ovarian Cyst		Vaginal Infections	
Cervical Cancer		Genital Herpes Exposure		Pelvic Inflammatory Disease		Sexual Infections	
Clotting Disorder		Heart Murmur		Polycystic Ovaries		Thyroid Disorder	
Congenital Heart Disease		Hemoglobinopathy		Prolapsed Uterus		Trauma or Violence	
Bladder Prolapse		Hepatitis/liver Disease		Premature Rupture of Membranes		Stroke	

Other medical problems:

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SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year they were performed.

	CONDITION:	DATE:		CONDITION:	DATE:		CONDITION:	DATE:
	Angioplasty			Carpal Tunnel			Hysterectomy	
	Angioplasty w/ Stent			Cataract Extraction			Knee Replacement	
	Appendectomy			Cesarean Section			Lasik	
	Arthroscopy			Cholecystectomy (Gallbladder removal)			Liver Biopsy	
	Augmentation Mammoplasty			Colectomy (Colon removal)			Mastectomy	
	Back Surgery			Colostomy			Reduction Mammoplasty	
	Blood Transfusion			Dilation and Curettage			Thyroidectomy	
	Bilateral Tubal Ligation			Gastric Bypass			Tonsillectomy	
	Breast Biopsy			Hernia Repair				
	Cardiac Pacemaker			Hip Replacement				

Other surgeries: _____

_____

MENSTRUAL / GYN HISTORY

First day of your last period: _____/_____/_____

What age did you start menstruating? _____

Are your periods regular (every month)? ❑ Y ❑ N

How many days does your period last? _____

Duration between periods: _____

Is your flow: light / medium / heavy

Do you have pain with your period? ❑ Y ❑ N

Any problems with your periods? ❑ Y ❑ N If so, explain _____

_____

Menopausal

Are you currently experiencing: ❑ hot flashes ❑ vaginal dryness ❑ mood changes

Are you currently on hormone replacement therapy? ❑ Y ❑ N Type / duration _____

Are you experiencing any vaginal bleeding/spotting since menopause: ❑ Y ❑ N

SEXUAL HISTORY

Are you currently sexually active: ❑ Y ❑ N Male / Female / Both

Total number of sexual partners: _____ Number of sexual partners currently _____

Are you experiencing any problems with intercourse? ❑ Y ❑ N

What contraception are you using? None / Condoms / Pills / Patch / Ring / Shot / IUD / Sterilization

Other: _____

Are you currently trying to become pregnant? ❑ Y ❑ N

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INFECTION HISTORY

Have you or do you currently have any of the following? Please mark all that apply.

	Chickenpox		Hepatitis B or C		Sexually transmitted infection
	Chlamydia		HIV		Syphilis
	Genital Herpes (you or partner)		Human Papilloma Virus (HPV)		Tuberculosis (you or family)
	Gonorrhea		Rash or viral illness since LMP		

OBSTETRIC / PREGNANCY HISTORY

Please list all your pregnancies (live births, miscarriages, ectopics, abortions, etc.) with details below:

Delivery Date/Time	# Weeks at Birth	Result of Pregnancy (vaginal or C-section)	Child's Sex	Weight	Delivery Hospital	Mother/Baby Complications	Neonate Outcome

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers				
Sisters				

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SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Do you use alcohol? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use Caffeine? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Do you use recreational drugs? No _____ Yes _____ Type _____ Amount _____ Frequency _____

Occupation _____ Employer _____

Do you exercise? No _____ Yes _____ Type(s) _____ Hours per Week _____

QUALITY OF LIFE

In past 2 weeks, have you had little interest or pleasure in doing things?

Not at all (0) _____ Several days (1) _____ More than half the days (2) _____ Nearly every day (3) _____

In past 2 weeks, have you been feeling down, depressed or hopeless?

Not at all (0) _____ Several days (1) _____ More than half the days (2) _____ Nearly every day (3) _____

DOMESTIC VIOLENCE

Have you ever been physically or emotionally abused by your partner? ❑ Yes ❑ No

Have you been physically hurt by someone within the past year? ❑ Yes ❑ No

If yes, number of times in the past year: _____ By whom: _____

Within the last year, has anyone forced you to have sexual activity? ❑ Yes ❑ No

If yes, number of times in the past year: _____ By whom: _____

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