

**Annual Exam/New Patient Medical History**

Patient Name: \_\_\_\_\_ Birthdate: / / \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Other Physician: \_\_\_\_\_  
 Reason for Visit: \_\_\_\_\_  
 Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

**Gynecologic History (Please Complete This Section)**

Your age at first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_ Previous period: \_\_\_\_\_  
 How long does your period last: \_\_\_\_\_ How many pads/tampons on worst day: \_\_\_\_\_  
 Are your periods regular: \_\_\_\_\_ Do you bleed or spot in-between: \_\_\_\_\_  
 Do you have pain with your periods: \_\_\_\_\_ Do you miss work: \_\_\_\_\_  
 Do you have problems with PMS: \_\_\_\_\_  
 Are you menopausal: \_\_\_\_\_ Have you had any bleeding since menopause: \_\_\_\_\_  
 Have you taken hormones: \_\_\_\_\_ Do you have hot flashes or other symptoms: \_\_\_\_\_

**Have you ever had the following:**

Thyroid Disease . . . . . yes / no  
 Diabetes . . . . . yes / no  
 Hypertension . . . . . yes / no  
 Cancer . . . . . yes / no  
 Stroke . . . . . yes / no  
 Heart trouble . . . . . yes / no  
 Arthritis/gout . . . . . yes / no  
 Convulsions . . . . . yes / no  
 Bleeding tendency . . . . . yes / no  
 Acute infections . . . . . yes / no  
 Venereal disease . . . . . yes / no  
 Hereditary defects . . . . . yes / no  
 Other: \_\_\_\_\_

Please Update Changes Since Last Annual Exam

What is your current method of birth control? \_\_\_\_\_  
 Have you ever used:  
 Pills  IUD  Diaphragm  Condoms  Foam  Vasectomy/tubal ligation  
 Have you ever had:  
 Herpes  GC  PID  Chlamydia  Venereal Warts/HPV  
 Does your partner have Herpes or HPV? \_\_\_\_\_  
 Have you ever had an abnormal Pap smear? \_\_\_\_\_ If yes, what happened? \_\_\_\_\_  
 \_\_\_\_\_  
 List previous hospitalizations / surgeries / serious injuries: \_\_\_\_\_ When: \_\_\_\_\_  
 \_\_\_\_\_  
 Monthly self breast exam? \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_  
 Regular exercise? \_\_\_\_\_  
 Seat belt use? \_\_\_\_\_ 1200mg calcium? \_\_\_\_\_ Last colon cancer screening: \_\_\_\_\_

**List Medications you are currently taking including nonprescription/herbals:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**Patient Social History**

Marital Status:  Single  Married  Separated  Divorced  Widowed  
 Use of Alcohol:  Never  Rarely  Moderate  Daily: \_\_\_\_\_  
 Use of Tobacco:  Never  Previously but quit  Current packs per day: \_\_\_\_\_  
 Use of Drugs:  Never  Type/Frequency: \_\_\_\_\_  
 Excessive exposure at home or work to:  Fumes  Dust  Solvents  Noise

**Do you have any Drug Allergies? If so, please list:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Review of Systems

Have you had any of the following during the past three months?

### URINARY

Frequent urination. . . . . No / Yes  
 Burning or painful urination. . . . . No / Yes  
 Blood in urine . . . . . No / Yes  
 Incontinence . . . . . No / Yes

### SKIN

Rash or itching . . . . . No / Yes  
 Varicose veins . . . . . No / Yes  
 Breast pain. . . . . No / Yes  
 Breast lump . . . . . No / Yes  
 Breast discharge. . . . . No / Yes

### CONSTITUTIONAL

Good general health lately. . . . . No / Yes  
 Recent weight change . . . . . No / Yes  
 Headaches . . . . . No / Yes

### EYES

Wear glasses/contact lens. . . . . No / Yes

### ENT

Sinus problems. . . . . No / Yes  
 Sore throat or voice change . . . . . No / Yes  
 Swollen glands in neck. . . . . No / Yes

### CARDIOVASCULAR

Heart trouble. . . . . No / Yes  
 Chest pains . . . . . No / Yes  
 Sudden heart beat changes. . . . . No / Yes  
 Swelling of feet, ankles or hands . . . . . No / Yes

### GASTROINTESTINAL

Loss of appetite . . . . . No / Yes  
 Change in bowel movements. . . . . No / Yes  
 Nausea or vomiting . . . . . No / Yes  
 Frequent diarrhea. . . . . No / Yes  
 Painful bowel movements or constipation. . . . . No / Yes  
 Blood in stool . . . . . No / Yes  
 Stomach pain. . . . . No / Yes

### NEUROLOGICAL

Frequent or recurring headaches . . . . . No / Yes  
 Light headed or dizzy . . . . . No / Yes  
 Numbness or tingling sensations. . . . . No / Yes

### PSYCHIATRIC

Nervousness. . . . . No / Yes  
 Depression. . . . . No / Yes  
 Sleep problems. . . . . No / Yes

### HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed. . . . . No / Yes  
 Anemia . . . . . No / Yes  
 Phlebitis. . . . . No / Yes  
 Past transfusion . . . . . No / Yes

### ALLERGIC

History of skin reaction or other adverse reactions to:  
 Penicillin or other antibiotics. . . . . No / Yes  
 Morphine, Demerol or other narcotics . . . . . No / Yes  
 Novocaine or other anesthetics . . . . . No / Yes  
 Aspirin or other pain remedies. . . . . No / Yes  
 Tetanus antitoxin or other serums . . . . . No / Yes  
 Iodine, methiolate or other antiseptic . . . . . No / Yes

Other drugs/medications \_\_\_\_\_

Known food allergies \_\_\_\_\_

### RESPIRATORY

Frequent Coughing . . . . . No / Yes  
 Shortness of Breath . . . . . No / Yes  
 Asthma or Wheezing. . . . . No / Yes

### ENDOCRINE

Excessive Thirst or urination . . . . . No / Yes  
 Heat or Cold Intolerance. . . . . No / Yes  
 Dry Skin . . . . . No / Yes

### MUSCULOSKELETAL

Joint Pain. . . . . No / Yes  
 Muscle Pain or Cramps . . . . . No / Yes  
 Back Pain. . . . . No / Yes

## Family Medical History (Please Update Changes Since Last Annual Exam)

Check here if there are no changes since your last visit

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father:			
Mother:			
Brother:			
Sister:			
Spouse:			
Pat. Grandfather:			
Pat. Grandmother:			
Mat. Grandfather:			
Mat. Grandmother:			
Other:			

**Obstetric History (Please Update Changes Since Last Annual Exam)**

List all abortions, miscarriages, tubal pregnancies:

<u>Date</u>	<u>Weeks</u>	<u>Abortion or Miscarriage</u>	<u>Complications</u>

Other pregnancies:

<u>Date</u>	<u>Months Pregnant</u>	<u>Sex of Infant</u>	<u>Alive or Stillborn</u>	<u>Living Now</u>	<u>Weight at Birth</u>	<u>Complications</u>

**Environmental History (Please Complete This Section)**

Do you have a history of abuse in your past or present?  Yes  No

**Sexual History (Please Complete This Section)**

- 1. Your age at first intercourse? \_\_\_\_\_
- 2. Number of partners (lifetime):  None  1-4  5 or more
- 3. Number of Partners Currently: \_\_\_\_\_
- 4. How often do you have intercourse? \_\_\_\_\_
- 5. Do you have pain with intercourse?  Yes  No
- 6. Do you have orgasms?  Yes  No
- 7. Do you have any problems with sex?  Yes  No
- 8. Are you currently married?  Yes  No No. of Years? \_\_\_\_\_
- 9. Ever married?  Yes  No
- 10. Do you consider yourself homosexual?  Yes  No

**Dietary History (Please Complete This Section)**

Answer the following questions based upon an average day.

- 1. Do you eat 3 dairy servings? \_\_\_\_\_
- 2. Do you eat 5 veggie/fruit servings? \_\_\_\_\_
- 3. How many sodas do you drink? \_\_\_\_\_
- 4. How many caffeinated beverages? \_\_\_\_\_
- 5. Do you eat a low-fat diet? \_\_\_\_\_