

**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)

Table with 3 columns: Name (Father, Mother, Siblings, Spouse, Grandparents), Age, Diseases, and If Deceased, Cause of Death.

Physician's Signature:

**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? \_\_\_\_\_