

New Patient History Form

Obstetrical Associates of St. Luke's

Note: this is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Name: _____ Appointment Date: _____ Date of Birth: __/__/__ Age: ____

How did you hear about our practice: _____

Who is your doctor in this office? _____ Who are you seeing today? _____

Pharmacy Name: _____ Pharmacy Phone Number: _____ Preferred Lab: _____

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be as specific as possible)

Past Medical History

Have you ever had any of the following? (Please circle all that apply)

Anemia	Seizures	Asthma	High Cholesterol
Heart Disease	Gall Bladder Disease	Migraines	Pneumonia
High Blood Pressure	Blood transfusion	Liver disease	Diabetes
Rheumatic Fever	Pelvic Infection	Depression/Anxiety	Sickle Cell Trait
Mitral Valve Prolapse	Bladder Infections	Drug or Alcohol Problems	Blood clot in leg/lung
Thyroid problem	Genital Herpes	Gonorrhea/Syphilis/Chlamydia	Osteopenia
Stroke	Tuberculosis	Kidney Stones/Infections	Bleeding Disorder
Emphysema/COPD	MRSA	Hepatitis B	Hepatitis C
Sleep Apnea	Breast Disease	Stomach/Bowel problems	
Glaucoma	Osteoporosis	Cancer	Type: _____
Other (please list details): _____			

Medication and Allergies

Are you on any medications? Y N (If yes, list all)	Do you have any allergies? Y N (If yes, list all)
_____ _____ _____	_____ _____ _____

Surgical History

Surgical History and dates

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Maintenance

Date of last mammogram: _____

Date of last Bone Density: _____

Date of last colonoscopy: _____

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Social History

Do you smoke? Y N How much? _____ For how long? _____
 Do you drink alcohol? Y N How much? _____ For how long? _____
 Do you use any street drugs? Y N If yes, please list _____
 Marital Status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed
 Sexual Orientation: _____
 Occupation: _____ Religion: _____

Past Obstetrical History

Please list all pregnancies in order (including miscarriages, premature births, abortions, ect.)

Year	Sex	Weight	Type of Delivery	Weeks Pregnant	Anesthetic	Complications

Past Gynecologic History

Previously sexually active? Y N Currently sexually active? Y N
 Have you been diagnosed with a sexually transmitted disease? Y N

If yes, please select below:

_____ Gonorrhea _____ Chlamydia _____ Genital Warts _____ HPV _____ Herpes
 _____ Syphilis _____ HIV

Indicate if any problems you have had either in the past or currently:

_____ Vaginal Infections _____ IUD Related problems _____ Pelvic Inflammatory Disease (PID)

Date of beginning of last menstrual period _____ Method of birth control _____

Age of first period _____ Pain or cramping? Y N

Cycle length _____ Cycle Frequency _____ Flow: Light Moderate Heavy

Date of last pap smear _____ Past abnormal pap smear? Y N

Have you had treatment from an abnormal pap smear? (please list what and when) _____

Have you received your Gardasil: Y N PARTIAL?

Family History

Has any relative ever had:	Who	Who	Who
Breast Cancer	_____	Uterine Cancer	_____
Colon Cancer	_____	Ovarian Cancer	_____
High Blood Pressure	_____	Pancreatic Cancer	_____
Epilepsy	_____	Stroke	_____
Osteoporosis	_____	Tuberculosis	_____
Mental Illness	_____	Sickle Cell Disease	_____
Diabetes	_____	Bleeding problems	_____
Other	_____	Autoimmune	_____
		Heart Trouble	_____
		Heart Disease	_____
		Inherited Disease	_____

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Review of Systems

Do you have any of the following problems? If so, please circle

General

Weight Changes >10 lbs
Fever
Fatigue
Headache

Skin

Rash/Sores
Mole Changes

Head and Neck

Visual Changes (not glasses)
Blurred Vision
Double Vision
Trouble Hearing
Sinus Problems
Sore Throat

Musculoskeletal

Joint Pain
Muscle Weakness
Muscle Pain

Respiratory/Lungs

Shortness of Breath
Wheezing
Cough
Sleep Apnea

Neuro

Numbness or tingling
Dizziness
Seizures

Cardiovascular

Chest Pain
Difficulty Breathing
Irregular rapid heartbeat
Swelling

Endocrine

Changes in hair/hair loss
Heat/Cold Intolerance
Frequent sweats/hot flashes
Excessive Thirst

Gastrointestinal

Nausea/Vomiting
Frequent heart burn/acid
Abdominal pain
Diarrhea (Frequent)
Constipation

Psych/Social

High anxiety/stress
Marital/relationship problems
Depressed mood/crying
Thoughts of Suicide
Forgetfulness/Confusion

Allergic/Immunologic

Hay Fever
Seasonal Allergies
Medications

Hematologic/Lymphatic

Swollen glands
Bruise/Bleed easily

Breast

Nipple Discharge
Lumps
Skin Changes

Genitourinary/Women

Pelvic Pain
Urine Leakage
Vaginal discharge
Abnormal bleeding
Menopause
Painful Periods
Decreased sexual desire
Frequent Urination
Burning with Urination
Vaginal dryness
Menstrual problems
Infertility
Painful intercourse

Covid-19 Vaccine

yes
no

If yes:

When? _____ Circle one: Pfizer Moderna Johnson & Johnson **Booster?** Yes No