

Date: _____

WEST END OB/GYN, PC

NEW PATIENT ENCOUNTER

Welcome to our office. Please take a few minutes to provide us with information to better serve you.

Name _____

Email _____

Pharmacy #: _____

Primary Care Physician (PCP) _____

What is the nature of your visit? Annual exam Consultation Other

Problem Visit (please explain) _____

How did you learn about this office? _____

Please list any **medical problems** that a doctor is treating. (Example: asthma, diabetes, depression, and hypertension) Please include the name of the doctor who cares for you.

_____	_____
_____	_____
_____	_____
_____	_____

Please list any previous **surgery**. (Example: tubal ligation, appendectomy, hysterectomy, colposcopy)

_____	_____
_____	_____
_____	_____
_____	_____

Please list current **medications** including dosing.

_____	_____
_____	_____
_____	_____
_____	_____

Please list any **allergies to medications**.

Please list all **other allergies**. (Example: latex, food)

_____	_____
_____	_____
_____	_____
_____	_____

Please check the box below if you have **previously received the Human Papilloma Virus (HPV) injection, also called Gardasil, at another medical facility.**

I have received the HPV vaccination. It was given to me at _____
(name of facility)

I received a total of (please check box) 1, 2, 3 HPV injections.

Please tell us about any **previous pregnancies.**

Does not apply, I have never been pregnant before.

_____ Total number of times pregnant

_____ Number of vaginal deliveries

_____ Number of miscarriages

_____ Number of C-sections

_____ Number of abortions

_____ Number of living children

Have you ever had any **previous GYN problems?** (Please check box for those that apply)

Abnormal pap's _____

Sexually transmitted diseases _____

Abnormal mammograms

Problems with menstrual cycle

Are you sexually active? Yes No

Do you use birth control? Yes No If so, what form: _____

Do you have a history of cold sores/fever blisters? Yes No

Family History: (check history that applies)

Hypertension

Diabetes

Heart Disease

Cancer of the colon

Cancer of the ovary

Cancer of the uterus

Cancer of the breast

High cholesterol

Other _____

Social History: (check history that applies)

Marital Status: Married, Divorced, Single, Widowed

Are you employed? Yes No What occupation? _____

Do you smoke or have a history of smoking? Yes No If so, how much _____ and for how long? _____

Do you use alcohol? Yes No If so, how often? _____

Illegal drug use, past or present? Yes No

Do you wear a seat belt? Yes No

Do you exercise regularly? Yes No

Have you ever experienced domestic abuse (physical or emotional)? Yes No

Review of Systems: (Please check all that apply currently or you still suffer with.)

Heart Palpitations

Weight Loss

Weight Gain

Vision problems

Hearing Problem

Chest pain

Pain urinating

Trouble breathing

Muscle pain/injury

Fever

Leaking urine

Skin problems

Emotional problems

Cough

New allergies

Constipation

Lymph node swelling

Diarrhea

Vomiting

Endocrine problems

Please explain any checked problems from above. _____
