

NORTH POINTE OB/GYN

New Patient Health History

Name _____ Today's Date _____

Why are you here today? _____

Primary / Family Physician _____

CURRENT MEDICATIONS NONE _____ _____ _____	MEDICATION ALLERGIES NONE _____ _____ _____	LATEX ALLERGY Y N
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MENSTRUAL HISTORY: 1st Day of Last Period _____

Age at First Period _____ **(ABNORMALITIES:)**

of days between periods _____ ___ Excessive bleeding ___ Mood swings ___ No bleeding

Length of period _____ ___ Pain ___ Irregular bleeding ___ Bleeding between periods

EXERCISE: Y ___ N ___

___ Active
 ___ Moderate active
 ___ Very active

PREGNANCY HISTORY											
# of Pregnancies		# of full term births		# of premature births		# of miscarriages		# of induced abortions		# of living children	
	Born Mo/Yr	Baby's Sex	Birth Weight	# of Weeks Pregnant	Hours in Labor	Type of Delivery	Pain Medication	Complications Y N			
1											
2											
3											
4											
5											

VACCINES:

___ HPV ___ Tetanus
 ___ Flu ___ Other

SUBSTANCE USAGE:

Y N

Alcohol ___ ___
 Tobacco ___ ___
 Caffeine ___ ___
 Street Drugs ___ ___

GYN History:

Have you ever had an abnormal pap?	Y N	Birth Control Method _____
Have you been sexually active?	Y N	Date of your last pap smear _____
Do you have pain with sex?	Y N	Have you had:
Do you have any urinary problems?	Y N	A mammogram? Y N When _____
Do you have any breast problems?	Y N	A bone density? Y N When _____
Do you have any problems with vaginal discharge?	Y N	A colonoscopy? Y N When _____
		Your cholesterol checked? Y N When _____

MEDICAL HISTORY:

No known medical problems _____

Have you had: Yes

- High Cholesterol _____
- Heart Disease _____
- High Blood Pressure _____
- Diabetes _____
- Asthma _____
- Thyroid Problems _____
- Kidney/Bladder Problems _____
- Blood Disorder/Anemia _____
- Breast Problems _____
- Cancer _____
- AIDS _____
- Chlamydia _____
- Gonorrhea _____
- Syphilis _____
- Herpes _____
- Hepatitis _____
- Birth Defects _____
- Physical Abuse _____
- Other Medical Problems _____

FAMILY HISTORY:

No known medical problems _____

Has anyone in your immediate family had: Yes

- High Blood Pressure _____
- Diabetes _____
- High Cholesterol _____
- Heart Disease/Attack _____
- Blood Disorder/Anemia _____
- Cancer _____
- Birth Defects _____
- Other Medical Problems _____

SURGICAL HISTORY:

Mo/Yr	Surgery	Complications	
		Y	N
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N

REVIEWED BY _____