Community
Westview Physicians

WESTVIEW WOMENS SPECIALTY CENTER

New Patient Intake Medical History Form

General Information

Name:_______________________ Date of Visit______________

Date of Birth:______________________ Age: ________________

Reason for Visit: ____

Past Obstetrical History:

Number of Pregnancies______________ Number of Deliveries ____________

# of Vaginal Delivery ____________________ Years ____________________

# of Cesarean Delivery ____________________ Years ____________________

# of Miscarriage/Abortions ____________________ Years ____________________

Past Gynecological History:

Post Menopausal Yes ☐ No ☐

Age of first period ____________________

Age of menopause ____________________

Are your periods monthly Yes ☐ No ☐

Number of days you bleed ____________________

Last Menstrual Period Date: ____________________

Last Pap Test/Pelvic Exam Date: ____________________

Abnormal Pap Yes ☐ No ☐
Date: ____________________

LEEP/CONE Yes ☐ No ☐
Date ____________________

Frozen cone/Cryo Yes ☐ No ☐
Date ____________________

Sexually Transmitted Infection Date ____________________

Sexually active in the past year Yes ☐ No ☐

Sexual Orientation Homosexual __________ Heterosexual __________

Number of sexual partners in the past year ____________________

Pain or discomfort with intercourse Yes ☐ No ☐

PLEASE COMPLETE THE BACK OF THIS FORM

Past Medical History:

- [ ] Thyroid Disease
- [ ] Arthritis
- [ ] Ulcer Disease
- [ ] Psoriasis
- [ ] Hepatitis, Cirrhosis
- [ ] Heart Attack
- [ ] Asthma
- [ ] Osteoporosis
- [ ] Gout
- [ ] Tuberculosis
- [ ] High Blood Pressure
- [ ] Diabetes
- [ ] Emphysema
- [ ] Seizures or Epilepsy

Other Illness ______________________ Year of onset ______________________

Psychological History:

○ Depression ○ Anxiety ○ Sexual abuse Year _______

○ Emotional abuse Year_______ ○ Physical abuse Year _______

○ Do you feel safe with your current partner? Yes ☐ No ☐

Past Surgical History:

	Year	Complications
☐ Hysterectomy	Year____________	Complications ____________
☐ Gall Bladder Removal	Year____________	Complications ____________
☐ D and C	Year____________	Complications ____________
☐ Bladder suspension	Year____________	Complications ____________
☐ Urinary Incontinence surgery	Year____________	Complications ____________
☐ Tubes tied	Year____________	Complications ____________

Other Procedure	**Year**	**Complications**
____________	____________	____________
____________	____________	____________

Allergies:

Medication	Type of Reaction	Year
____________	____________	____________

Current Medications/Dose:	**Current Medications/Dose**
____________	____________
____________	____________
____________	____________
____________	____________

Immunizations: Year

- [ ] Tetanus ____________
- [ ] Influenza/Flu ____________
- [ ] Pneumovax ____________

Diagnostic Studies: Year

- [ ] PPD (tuberculosis test) ____________
- [ ] EKG ____________
- [ ] Treadmill/Exercise Stress Test ____________
- [ ] Chest XRAY ____________
- [ ] Bone Density ____________
- [ ] Sigmoidoscopy/Colonoscopy ____________
- [ ] Mammogram ____________

Social History:

Tobacco:

1. Do you live with or have you ever lived people who smoke?
   Yes ☐ No ☐
2. Have you ever used tobacco Yes ☐ No ☐

Patient Name:________________________________

4. Do you currently use tobacco Yes ☐ No ☐
Number of cigarettes per day ________________
Number of cigars/pipes per day ________________
Number of times you use smokeless tobacco ________________

Alcohol:
1. Do you drink alcoholic beverages: Yes ☐ No ☐
If yes, please identify which of the following you consume

☐ Beer Number/week __________
☐ Wine Number/week __________
☐ Liquor Number/week __________

2. Have you used alcohol, but quit Yes ☐ No ☐

3. Do you have or have ever had problems with excessive alcohol use
Yes ______ No _________

Illicit/Recreational Drugs:
Do you now or have you ever used recreational drugs Yes ☐ No ☐
If yes, Drug ______________________ Amount Daily ________________

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed

Highest Educational Level:
Grade in School ☐7 ☐8 ☐9 ☐10 ☐11 ☐12
College ☐13 ☐14 ☐15 ☐16
Graduate School ☐17 ☐18 ☐19 ☐20

Occupation:
____

Family History:
Are you adopted or unaware of your parent's medical history?
Yes ☐ No ☐
Check if anyone in your family has had any of the following:

Disease	Mother	Father	Siblings	Grandparents/Other
Asthma				
Alcoholism/Drug addiction				
Anemia				
Arthritis/Rheumatism				
Blood Clots				
Breast Cancer				
Colon/Rectal Cancer				
Convulsions/Seizures/Epilepsy				
Cancer (other)				
Colitis				
Diabetes				

Deafness				

PLEASE COMPLETE THE BACK OF THIS FORM

Disease	Mother	Father	Siblings	Grandparents/Other
Eczema				
Hepatitis/Liver Disease				
Heart Disease				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Lupus				
Chronic Muscular disease				
Chronic Neurological disease				
Pancreatitis				
Sleep Apnea				
Thyroid Disease				
Osteoporosis				
Other (please specify)				

Review of Systems:

Check all symptoms that you have ever had a significant problem with in the past year.

General
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain
- ☐ Chronic Fatigue
- ☐ Change in Appetite
- ☐ Night Sweats
- ☐ Unexplained Fevers or Chills

Heart/Vascular
- ☐ Chest Pain or Pressure
- ☐ Rapid/Irregular Heart Beats
- ☐ Fainting/Lightheadedness
- ☐ Calf Pain
- ☐ Varicose Veins

Eyes
- ☐ Double Vision
- ☐ Decrease in Vision
- ☐ Injury to the Eye

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Snoring
- ☐ Sinus Infection
- ☐ Ringing in the ears

Musculo-Skeletal
- ☐ History of Fracture
- ☐ Low Back Pain
- ☐ Chronic Joint and Muscle Pain

Endocrine
- ☐ Low Blood Sugar
  - ☐ Hair loss
  - ☐ Dry skin
  - ☐ Irregular periods

Pulmonary
- ☐ Chronic Cough or Phlegm
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough up Blood
- ☐ Shortness of Breath

Gastrointestinal
- ☐ Fatty Food Intolerance
- ☐ Heartburn
- ☐ Gallbladder Trouble
- ☐ Jaundice
- ☐ Lactose Intolerance
- ☐ Blood in Stools
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea

Neuropsychiatry
- ☐ Loss of Consciousness
- ☐ Vertigo
- ☐ Headaches
- ☐ Nervous Breakdown
- ☐ Numbness or Tingling

Hematology
- ☐ Anemia
- ☐ Blood clots
- ☐ Enlarged Lymph Nodes

Dermatology
- ☐ Skin Rash
- ☐ Moles
- ☐ Shingles
- ☐ Sores that won't Heal
- ☐ Skin or Toenail Fungus

Genitourinary
- ☐ Vaginal Discharge/Odor
- ☐ Vaginal Dryness
- ☐ Pain with Intercourse
- ☐ Burning with Urination
- ☐ Blood in Urine
- ☐ Low Libido
- ☐ Pelvic Pain
- ☐ Kidney Stones
  - ☐ Urinary Incontinence
  - ☐ Postmenopausal bleeding
  - ☐ Bleeding between periods

Referring Physician____