New Patient Information & History

Patient _____ Occupation _____

Reason for appointment _____

Gynecologic History

First day of last period: _____
How many days between first days of each periods: _____ Duration of bleeding (in days): _____
Does bleeding occur between periods: ___ YES ___ NO
Does bleeding occur after intercourse: ___ YES ___ NO
Do you have pain with your periods: ___ YES ___ NO
Flow: ___Light ___ Normal ____ Heavy ___ Clots
Do you ever flood through your clothes: ___ YES ___ NO
Birth Control: _____
Age of menopause (if applicable): _____
Have you ever been on hormone replacement therapy: ___ YES ___ NO
Have you ever had: ___ Chlamydia ___ Gonorrhea ___ Genital Warts/HPV ___ Genital Herpes
Last pap smear: _____ Normal: ___ YES ___ NO
Have you ever had an abnormal pap smear: ___ YES ___ NO

Obstetrical History

Have you ever been pregnant: ___ YES ___ NO
Please list ALL pregnancies below, including abortions, miscarriages, and ectopic (tubal) pregnancies.

Delivery date	Location of delivery	# of wks pregnant at delivery	Hours of labour	Type of delivery	Complications	Baby's gender	Baby's birth weight	Present health

Social History

Marital Status:
___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ In a relationship

Any concerns about safety in your relationship? ___ NO ___ YES

Smoking Status:
Tobacco: ___ NO ___ YES ___ Quit If yes, number is cigarettes a day: _____
Marijuana: ___ NO ___ Daily ___ Occasionally ___ Topical/Edibles

Alcohol: ___ NO ___ YES Number of drinks a week: _____

Recreational drugs: ___ NO ___ YES Type: _____

Medical History (check all that apply to you):

High Blood Pressure	Blood Clot in leg/lung	Migraines
Diabetes- Type 1 or Type 2	Blood Transfusion	Sleep Apnea- On CPAP ___YES ___NO
Asthma	Depression	Cancer- Type _____
Heart Attack	Anxiety	Stroke
Thyroid- Hypo or Hyper	Other _____	

Have you ever had problems with anesthesia ___ YES ___ NO

Surgical History (List all surgeries you have had):

_____

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

Allergies (List drug/food and reaction):

_____

Family History (check all that apply and list relative):

Breast Cancer _____	Colon Cancer _____	Ovarian Cancer _____
Uterine Cancer _____	Cervical Cancer _____	Blood Clots _____

Anaesthesia Problems _____

Other _____

Please list any other relevant medical information below: