2840 Legacy Drive, Suite 400
Frisco, Texas 75034
P: 469-476-5623 F: 469-476-5624

New Patient History Form

OB History

Total Number of Pregnancies: ____________ Abortions: ____________ Miscarriages: _____________

Premature births: _______________ Live births: _______________ Living children: _______________

List *all* pregnancies:

Date	Vaginal/Cesarean (V/C)	# weeks pregnant	Baby's Weight	M/F	Complications

GYN History

Date of last menstrual period:_______________

Age of first menstrual cycle? _______________

Are your cycles regular? __________________

How many days do they last? ______________

Date of last pap smear?__________________

Have you had any abnormal pap smears?
☐ Yes ☐ No

Have you received the HPV vaccine?
☐ Yes ☐ No

Are you currently sexually active? ___________

If not, have you ever been sexually active?
☐ Yes ☐ No

At what age was your first intercourse? _______

# of sexual partners? _____________________

Do you currently have a partner? ____________
☐ Men ☐ Women ☐ Both

Have you ever been treated for sexually transmitted infections? ☐ Yes ☐ No

If yes, when? ___________________________

If yes which one: Gonorrhea, Chlamydia, Syphilis, Herpes, Condyloma, PID

Have you ever been sexually abused, threatened or hurt by anyone? ☐ Yes ☐ No

Have you ever been tested for HIV?
☐ Yes ☐ No

What were the results?
☐ Pos ☐ Neg

If in menopause, at what age did it occur?_____

Years of hormone replacement therapy? ______

Date of last mammogram? _________________

Have you had any abnormal mammograms?
☐ Yes ☐ No

If yes, when? Month/Year_________________

Have you had any breast biopsies?
☐ Yes ☐ No

Result?: _______________________________

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Current Method of Birth Control: ____

Previous Method of Birth Control: ____

Medical History

List all medical problems (Ex: high blood pressure, diabetes, hypothyroidism, etc)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Have you had a blood transfusion? ☐ Yes ☐ No If yes, when: ______________________

Medications

Include over the counter medications and supplements

Name:	Dose:

Allergies

List any medications or foods that you are allergic to (and the reaction)

Name:	Type of Reaction:

Surgical History

List any surgeries you have had and the approximate date

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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Social History

Occupation: ____________________________

# of Children:_________________

Pets: ________________________

Tobacco: ☐ Yes ☐ No ☐ Quit # of cigarettes/day: _______ # of years: _______ years quit: _______

Alcohol: ☐ Yes ☐ No ☐ Quit # of drinks/day: _____________ type: _____________

Drugs: ☐ Yes ☐ No ☐ Quit ____

Exercise: ☐ Yes ☐ No # times/week: _____________ type: _____________

Seat belt use: ☐ Yes ☐ No

Family History

List any medical conditions of your relatives (Parents, siblings, children)

Diabetes: ☐ Yes ☐ No Who: _______________________________

Hypertension: ☐ Yes ☐ No Who: _______________________________

Thyroid disease: ☐ Yes ☐ No Who: _______________________________

Osteoporosis: ☐ Yes ☐ No Who: _______________________________

Blood clots: ☐ Yes ☐ No Who: _______________________________

Cancer:

Breast ☐ Yes ☐ No Who: _______________________________

Uterine ☐ Yes ☐ No Who: _______________________________

Ovarian ☐ Yes ☐ No Who: _______________________________

Colon ☐ Yes ☐ No Who: _______________________________

Other: ________________ Who: _______________________________