FOXHALL OB/GYN ASSOCIATES

New Patient Form

Name:	Date:	Account No:
DOB (mm/dd/yyyy):	Primary Care Physician:	

PAST GYNECOLOGICAL HISTORY (Please circle all that apply currently or in the past)

Fibroids	Endometriosis	Ovarian Cysts	Infertility	Ovarian Cancer	Cervical Cancer	Uterine Cancer
Gonorrhea	Chlamydia	Syphilis	Genital Warts	Genital Herpes	Pelvic Inflammatory Disease	HIV

MENSTRUAL HISTORY

Date of last menstrual period?	_____/_____/_____
Is your period regular?	**Y / N** Age at menopause_____(if applicable)
How often do you get your period?	Every_____ days (please provide a range)
How would you describe your bleeding with your period?	**Normal / Mild / Moderate / Heavy Clotting**
Do you have pain with your period?	**Y / N**

CERVICAL CANCER SCREENING

Date of last pap smear?	_____/_____/_____ **Normal / Abnormal**
Have you ever had an abnormal pap smear?	**Y / N** If Yes, when?
Have you ever had a colposcopy?	**Y / N** If Yes, when?
Have you ever had cervical dysplasia?	**Y / N** If Yes, when?
Have you ever had cryotherapy, laser ablation, or a LEEP?	**Y / N** If Yes, when?

SEXUAL HISTORY

Are you sexually active?	**Y / N**
How would you define your gender identity?	**Female / Male / Transgender**
How would you define your sexual orientation?	**Heterosexual / Homosexual / Bisexual / Unsure / Other**
Do you use condoms?	**Always / Sometimes / Never**
Have you had greater than 5 sexual partners in your lifetime?	**Y / N**

CONTRACEPTION

Are you currently using birth control?	**Y / N**
If Yes, what method?	

PAST OBSTETRICAL HISTORY (Please list all previous pregnancies)

MM/DD/YYYY	Gestational Age	Length of Labor	Weight(lbs)	SEX	TYPE OF DELIVERY (Please circle)	COMPLICATIONS	Physician / Hospital
				M / F	Vaginal / C-section / Vacuum / Forceps		
				M / F	Vaginal / C-section / Vacuum / Forceps		
				M / F	Vaginal / C-section / Vacuum / Forceps		
				M / F	Vaginal / C-section / Vacuum / Forceps		

Have you had any miscarriages? **Y / N** If Yes, how many? _____

Have you terminated any pregnancies? **Y / N** If Yes, how many? _____

FOXHALL OB/GYN ASSOCIATES

Name: _____ **DOB:** _____ **Account No:** _____ **NEW PATIENT FORM**

PAST MEDICAL HISTORY (Please circle all that apply currently or in the past)

High Blood Pressure	High Cholesterol	Thyroid Disorder	Diabetes	Asthma	Bleeding Disorder
Depression	Anxiety	Migraines	History of DVT/PE	Gastric Reflux	Gastric Ulcer
Eating Disorder	Heart Disease	Urinary Incontinence	History of Falls	Osteoporosis	Bone Fracture
Breast Cancer	Colon Cancer	Genetic Disorder	Sleep Apnea	Kidney Disorder	Breast Mass

Other: _____

PAST SURGICAL HISTORY (Please list all past surgeries or procedures)

DATE	PROCEDURES	COMPLICATIONS

MEDICATIONS/SUPPLEMENTS (Please list all current medications and/or supplements)

MEDICATION/SUPPLEMENT	DOSE	INDICATION (Why are you taking this medication?)

ALLERGIES (Please list all allergies, including medications, latex and/or foods) **If none, please check here: □ NKDA**

_____

_____

FAMILY HISTORY (Is there a Family History of the following? Please note **relationship** and **age** of relative)

Breast Cancer:	Ovarian Cancer:	Uterine Cancer:	Colon Cancer:	Melanoma:	Pancreatic Cancer:
Osteoporosis:	Genetic Disorders:	Autism/ Developmental Disorders:	Early Menopause:	Heart Disease:	Blood Clotting Disorders:

SOCIAL HISTORY

Do you smoke cigarettes?	**Currently / Former / Never** If currently, how many cigarettes per day?____
Do you drink alcohol?	**Y / N** If Yes, how much_____per week
Do you use recreational drugs?	**Y / N** If Yes, which ones and how often?
Do you feel safe at home?	**Y / N**
What is your relationship status?	**Single / Dating / Engaged / Married / Divorced / Widowed**
Do your religious beliefs prohibit your acceptance of blood products?	**Y / N**
What is your occupation?	

PREVENTATIVE CARE

Did you receive the Gardisil Vaccine for HPV?	**Y / N** If Yes, did you receive all 3 doses? **Yes / No**
Do you perform self-breast exams?	**Y / N** If Yes, how often? **Rarely / Frequently / Monthly**
Have you ever had a mammogram?	**Y / N** If Yes, when? _____ **Normal / Abnormal**
Have you ever had a colonoscopy?	**Y / N** If Yes, when? _____ **Normal / Abnormal**
Have you ever had a DEXA/Bone Density Scan?	**Y / N** If Yes, when? _____ **Normal / Abnormal**
Do you exercise?	**Y / N** If Yes, how often_____ / week