New Patient History

Patient Name___________________________________ Date:_______________________________

Reason for Visit: Annual Exam Problem Visit (circle one)
If Problem Visit, Please explain:____

Social History:
Current Tobacco Use: Yes No Packs/day:______ Year started:___________________
Former Tobacco use Yes No Packs/day______ Year Started:_______Year Stopped:_________
Alcohol: Yes No Drinks per week:_____________
Exercise: Yes No Times/week: ________ Type of exercise:_____________
Marital Status: Single Married Divorced Widowed

Medical History:
Primary Care Physician____

Other treating Physicians ______________________________ For:_______________________________
______________________________ For:_______________________________
______________________________ For:_______________________________

Medical Illnesses: (Check all that apply)

( ) High Blood Pressure
( ) Heart Disease
( ) Heart Attack
( ) Psychiatric Disorder
( ) Thyroid Disease
( ) High Cholesterol
( ) Stroke
( ) Depression / Anxiety
( ) Diabetes
( ) Arthritis

List any other medical issues:____
____

Menstrual History:
Date your last menstrual period started:______________
Menopausal: Yes or No (circle one) If Yes, age of onset:________________
Have you had a Hysterectomy: Yes or No (circle one) If Yes, please give date?__________Reason?_________________
How often does your menstrual cycle start? Every ______________ Days or Weeks (circle one)
How many days do you normally bleed?_________________
Pad/Tampon changes per day of cycle: 4/day 6/day 8/day other_______________________
Do you experience cramps? Yes No Mild Moderate Severe
Do you take anything for cramps? Yes No What do you take?___________________

Date of last pap smear:_______________________
Do you have a history of abnormal pap smears? Yes No Date:________________________
Treatment____
Do you have a history of Herpes ν Gonorrhea ξ Chlamydia ξ Genital Warts ξ other STD's ξ
Date of onset______________________

Contraception: Are you trying to conceive? Yes No
Are you currently using a method of contraception? Yes No
Please **circle** all that apply:

Abstinence Withdrawal Condoms Birth Control Pills Patch Essure Rhythm
Injectable IUD Vasectomy Tubal Ligation Nuva Ring Nexplanon

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Other:

Do you perform self breast exams monthly? ☐Yes ☐No ☐occasionally
Have you had a mammogram? ☐Yes ☐No
Date of last mammogram_______________
Have you had a tetanus or TDAP booster in the last 10 years? Yes No Do you want one today? ☐Yes ☐No
Have you ever had a bone density? ☐Yes ☐No
Date_________________ Results____
Have you ever had a colonoscopy or Cologuard?: (circle one)☐Yes ☐No
Date of last test?_________________________Recommended Repeat Date: _______________________

Pregnancy History:

Total Pregnancies:______ Full Term:_____ Premature:_____ Miscarriages:______ Abortions_____

Date	Type of Delivery	Name of Child	Boy/Girl	Weight	Wks Gestation	Complications

Surgical History:

Please List any surgical procedures that you have had in the past:

Date	Operation	Physician	Complications

Please list any other hospitalizations or injuries and the date of each:
Surgery/Hospitalization:__________________________ Date:______________________________
Surgery/Hospitalization:__________________________ Date:_______________________________

Medications:

Please list all current medications & dosages (Prescription, Non-Prescription, Vitamins or Supplements including calcium or herbal supplements) If you need additional space, please use the back of this form and check here ☐
Medication:________________________________Dosage:____________________________
Medication:________________________________ Dosage:____________________________
Medication:________________________________ Dosage:____________________________
Medication:________________________________Dosage:____________________________
Medication:________________________________ Dosage:____________________________
Medication:________________________________ Dosage:____________________________

Allergies:

Please list all allergies to medications, food or latex along with your reaction, or circle NONE KNOWN
Allergic to: __________________________ Reaction:_________________________
Allergic to: __________________________ Reaction:_________________________
Allergic to:___________________________ Reaction:_________________________
Allergic to:___________________________ Reaction:_________________________

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New Patient History

FAMILY MEDICAL HISTORY Other than Hereditary Cancer Syndromes, please list any family medical history that you are aware of:

Illness	Relative	Maternal Or Paternal side of family	Age at Diagnosis	Comments	Are they still living? Yes or No

Family History Questionnaire for Common Hereditary Cancer Syndromes

Please mark below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Have you ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If Yes, the results were:____
Has any member of your family ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If yes, the results were:____
If you answered yes to either questions above, please obtain copy of relatives test results.

Breast and Ovarian Cancer	You	Age at diagnosis	Siblings/ children	Age at diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Breast Cancer (male or female)								
Ovarian Cancer								
Breast cancer in both breasts OR Multiple primary breast cancers								
Male Breast Cancer								
Pancreatic Cancer								
Prostate Cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Colon and Uterine Cancer	You	Age at diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Uterine (endometrial) Cancer								
Colorectal Cancer								
10 or more cumulative colon polyps								