NorthEast Women's Health and Obstetrics

PATIENT HISTORY FORM			
Date:		**Phone Number:**	
First	Middle:	Last:	Name you wish to be called:
Date of Birth:	Age:	Race:	Marital Status:
Birth Control Method:			Tubal or Vasectomy
Number of Pregnancies:		Number of Births:	Number of Miscarriages:
Traumatic Births:	C-Section:	Drug Allergies:	
Describe in Detail the Reason for Today's Visit:			
(Physician Use Only)			
			Mammogram
			DEXA
			Colonoscopy
			2 3 4 5
A total of _____ minutes was spent with the patient on the problem related portion of the encounter. Over half of that time was spent counseling the patient regarding the below listed problem(s). James P. Moon, MD			
List any operations and dates:			
List any medical conditions:			
Current Medications and Dosage:			
Pharmacy and Location:			
MENSTRUAL/ GU			
First day of Last Period:		Date of Previous Period:	Are they regular? (Y / N)
Period comes every	days, and lasts	days. Clots: (Y / N)	Spotting between Periods: (Y / N)
Cramps are *(select)*:	Mild	Moderate	Severe None
Do you have pain (Y / N)	or bleeding (Y / N)	with intercourse?	
Notes:			
Date of Last Pap Smear:		Do you have a history of abnormal pap (s)? (Y / N)	
Leakage of urine with coughing sneezing or laughing? (Y / N)		Frequent urination? (Y / N)	
Do you have vaginal pressure, protrusion or sensation of falling out? (Y / N)			
Please complete other side of this form.			

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GASTROINTESTINAL

Do you have pain? (Y / N) with bowel movements?

Frequent constipation? (Y / N) Diarrhea? (Y / N) Recent change in bowel movements? (Y / N)

Hemorrhoids? (Y / N) Have you ever been diagnosed with Irritable Bowel Syndrome? (Y / N)

BREASTS –Do you have these symptoms in either breast?

Lumps (Y / N) Discharge (Y / N) Pain (Y / N)

Mother, Sister or daughter with Breast Cancer? (Y / N)

CONSTITUTIONAL - Have you had fevers? (Y / N) Unexplained weight change? (Y / N)

HEMATOLOGICAL- Do you have a history of blood clots? (Y / N) Anemia? (Y / N)

ENDOCRINE - Do you have any abnormal hair growth? (Y / N) Acne? (Y / N)
Severe Hot Flashes/Night Sweats? (Y / N)

SKIN - Do you have any abnormal skin lesions? (Y / N)

LUNGS - Shortness of Breath? (Y / N)

HEART - Have you ever experienced palpitations? (Y / N)

EXTREMETIES - Do you have swelling? (Y / N) Numbness? (Y / N)

CNS - Do you have: History of Seizures? (Y / N) Severe Headaches? (Y / N)

PSYCHIATRIC

Are you bothered with depression, anxiety, or mood instability? (Y / N)

Do you smoke? (Y / N) How many packs per day?

Do you drink Alcohol? (Y / N) How many drinks per day?

Do you have a history of substance or drug abuse? (Y / N)

Occupation: Religion:

Family History – check any illnesses in your family & which family member diagnosed:

	Mother	Father	Sister	Brother
Heart disease				
Cancer / Female, Breast, Colon				
High Blood Pressure				
Thyroid disease				
Diabetes				
Respiratory problems				

Any other problems you think we should be aware of?

Patient signature: *Date:* *Physician's signature:*

For Office Use Only

Reviewed By:

Labs

BP	UA	LMP
Ht	Hgb	GA
Wt	UPT	EDC
Temp	Hemoccult	
BMI	Wet Mount	
Pain rating		