



# WELCOME TO OUR PRACTICE

(NEW PATIENT FORM)

55 Brunswick Woods Drive  
East Brunswick, NJ 08816  
(732) 927-1224

<http://www.obgynclinic.org>

## Personal Profile

Name: \_\_\_\_\_  
FIRST LAST

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

School Completed:  Yes or  No

Graduate Degree  College  High School  Other

Primary Care Physician: \_\_\_\_\_

Pharmacy: \_\_\_\_\_  
NAME ADDRESS ZIP CODE

Who may we thank for referring you to our practice: \_\_\_\_\_

Are You Here Today For: \_\_\_\_\_

## Gynecologic History

1). Are you currently pregnant?  Yes  No

Current Birth Control:  Yes  No

Last Menstrual period (First Day): \_\_\_\_\_

Age periods began: \_\_\_\_\_ Number of days bleeding: \_\_\_\_\_

Number of days between periods: \_\_\_\_\_

Any recent changes in periods?  Yes  No

Any pain during cycle:  Yes  No

2). Last Pap Smear: Abnormal Pap in the past?  Yes  No

History of fibroids:  Yes  No

History of ovarian cysts:  Yes  No

History of STIs? if yes, wich ones? \_\_\_\_\_

## Please list each pregnancy below (Pregnancy History)

	Date of birth	Weight	Sex	Weeks pregnant	Complications	Type of delivery (vag/ c-section)
1).	_____	_____	_____	_____	_____	_____
2).	_____	_____	_____	_____	_____	_____
3).	_____	_____	_____	_____	_____	_____
4).	_____	_____	_____	_____	_____	_____
5).	_____	_____	_____	_____	_____	_____

3). Abnormal mammograms in the past? Yes or No

Last Colonoscopy: \_\_\_\_\_ Last Bone Density scan: \_\_\_\_\_

Last Mammogram \_\_\_\_\_

Are you currently sexually active: Yes or No Menopause: Yes or No

History of infertility: Yes or No Pain during intercourse: Yes or No

Bleeding during intercourse:  Yes or  No

Vaginal Discharge:  Yes or  No

History of Sexually transmitted Disease:  Yes or  No

If Yes (Circle all that apply): Herpes, Gonorrhea, Chlamydia, Genital Warts  
Trichomonas, HIV, Syphilis,

Total Number of Partners: \_\_\_\_\_ Sexual preference: Male, Female, other

Do you desire STD testing?  Yes  No

## Obstetric History

Total number of pregnancies: \_\_\_\_\_

Pregnancy type: \_\_\_\_\_

How many full term: \_\_\_\_\_

Premature(<37wks): \_\_\_\_\_ Still

Born: \_\_\_\_\_ Tubal Pregnancies: \_\_\_\_\_

Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

Living Children: \_\_\_\_\_

Any Complication during pregnancy:  Yes  No

Were you considered High risk patient: Yes or No

If Yes, explain why: \_\_\_\_\_



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### Use of Tobacco:

Never\_\_\_\_ Previously, (But Quit)\_\_\_\_ Current # packs per day\_\_\_\_  
Use of Street Drugs: Marijuana:\_\_\_\_ Cocaine:\_\_\_\_ Crystal Meth:\_\_\_\_ Other\_\_\_\_\_

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

Domestic Violence  Yes  No

Regular Exercise  Yes  No

Do you currently drink alcohol?  Yes  No If yes, How much?

### Operations/ Hospitalizations (Include approximate dates)

Hospital	Complication
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

### Medications (Include over-counter)

Drug Name/Dose	
1. _____	2). _____
3). _____	4). _____
5). _____	6). _____

### Medication Allergies:

1). _____	2). _____
3). _____	4). _____
5). _____	6). _____

### Social History

Use of Alcohol:  
Rarely\_\_\_\_ Never\_\_\_\_  
Daily\_\_\_\_ Moderate\_\_\_\_

### Personal Medical History

1). _____	2). _____
3). _____	4). _____
5). _____	6). _____

### Cardiovascular:

- Arrhythmia
- Blood Clot in Leg or Lungs

Where:\_\_\_\_\_

- Chest Pain
- Congestive Heart Failure
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Mitral Valve Prolapse
- Pacemaker
- Stent

### Respiratory:

- Asthma
- Bronchitis
- Emphysema/COPD
- Pulmonary Embolism
- Sleep Apnea
- Shortness of breath
- Tuberculosis
- Pneumonia
- Gastrointestinal:
- Vomiting
- Acid Reflux
- Crohns Disease
- Ulcer
- Unexplained Weight Loss Or Gain
- Constipation
- Bowel Problems

### Hepatic/Liver Disease:

- Cirrhosis
- Hepatitis A B C
- Pancreatitis

### Infectious Disease:

- HIV
- MRSA
- Tuberculosis
- Rheumatic
- Kidney Stones
- Urinary Tract Infection

### Neurologic:

- ADHD
- Alzheimer's
- Diabetic
- Multiple Sclerosis
- Parkinson's
- Polio
- Seizure/Convulsion/Epilepsy
- Stroke
- TIA
- Migraine Or Headaches
- Numbness

### Endocrine:

- Adrenal abnormality
- Diabetes
- Osteoporosis
- Thyroid Disease
- Abnormal Hair Growth Or Loss

### Musculoskeletal:

- Lupus
- Osteoarthritis
- Rheumatoid Arthritis
- Gout
- Ankylosing Spondylitis
- Arthritis/Joint Pain
- Fracture

### Psychiatric:

- Acute stress disorder
- Anxiety
- Bipolar
- Depression
- Panic disorder
- Schizophrenia

Cancer: List:\_\_\_\_\_

### Gyn:

- Abnormal painful/heavy periods
- History of blood transfusion
- Would you accept a blood transfusion?
- Yes  No
- Infertility
- Herpes
- Lumps or breasts pain
- Nipple discharge
- Uterine fibroids



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## Gyn (cont.)

- Vaginal discharge
- Rash
- Involuntary loss of urine

## Family History Non Contributory

### Mother

- Living
- Decease/Cause of death \_\_\_\_\_

### Father

- Living
- Decease/Cause of death \_\_\_\_\_

### Siblings

- Living
- Decease/Cause of death \_\_\_\_\_

### Children

- Living
- Decease/Cause of death \_\_\_\_\_

### Maternal Grandmother

- Living
- Decease/Cause of death \_\_\_\_\_

### Maternal Grandfather

- Living
- Decease/Cause of death \_\_\_\_\_

### Paternal Grandmother

- Living
- Decease/Cause of death \_\_\_\_\_

### Paternal Grandfather

- Living
- Decease/Cause of death \_\_\_\_\_

## Illness

- Age of onset \_\_\_\_\_
- Which Realtives \_\_\_\_\_
- Birth Defects \_\_\_\_\_
- Blood Clots In Legs/Lungs \_\_\_\_\_
- Breast Cancer \_\_\_\_\_ Colon
- Cancer \_\_\_\_\_ Ovarian
- Cancer \_\_\_\_\_ Uterine
- Cancer \_\_\_\_\_
- Any Other Cancer \_\_\_\_\_ Cystic
- Fibrosis \_\_\_\_\_ Downs
- Syndrome \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Cholesterol \_\_\_\_\_
- Sickle Cell Disease \_\_\_\_\_
- Stroke \_\_\_\_\_

Please check any symptoms, which you are currently experiencing: \_\_\_\_\_

## Review of system

### Constitutional:

- Negative
- Fatigue
- Weight loss
- Weight gain
- Fever

### Head, Ears, Nose, Throat/Eyes:

- Negative
- Headache
- Sore throat
- Decreased hearing
- Vision change
- Glasses/contacts
- Tinnitus
- Ulcers
- Sinusitis
- Other



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## Breast:

- Negative
- Breast lumps
- Breast tenderness
- Mastalgia (painful breast)
- Nipple discharge

## Cardiovascular:

- Negative
- Chest pain
- Irregular heartbeat
- Palpitation
- Orthopnea
- DOE
- Edema
- Other\_\_\_\_\_

## Respiratory:

- Negative
- Cough
- Wheezing
- Shortness of breath
- Hematopsis

## Genitourinary

- Negative
- Bloody urine
- Incontinent
- Urgency
- Frequency
- Incomplete emptying
- Abnormal bleeding
- Pain with intercourse
- Dysuria
- Dyspareunia

## Musculoskeletal/Neurological

- Negative
- Dizziness
- Numbness
- Muscle weakness
- Trouble Walking

## Skin

- Negative
- Discharge
- Masses
- Rash
- Ulcer
- Other\_\_\_\_\_

## Psychiatric

- Negative
- Depression
- Anxiety
- Schizophrenia
- Other\_\_\_\_\_

## Hematology/Lymph

- Negative
- Easy bruising
- Bleeding problems
- Adenopathy (Swollen lymph nodes)
- Other\_\_\_\_\_

Describe:\_\_\_\_\_

## GI / Digestive

- Negative**
- Diarrhea
- Constipation
- Flatulence
- Abdominal Pain
- Bloody Stool
- Nausea/Vomiting
- Other

## Endocrine

- Negative**  Hypothyroidism  Hypothyroidism
- Hot Flashes  Diabetes

## THANK YOU!

Most insurance carriers will cover your Annual Well Woman Exam once per calendar year. Your Well Woman Exams consists of a breast exam, pelvic exam and pap smear. If you're experiencing any issues, and wish to be evaluated, then you are not considered a "well woman" and your visit is no longer considered preventative. Additional services may be billed for any additional issues discussed resulting in patient responsibility, dependent upon your individual benefits.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_