New OB/GYN Patient Form

Sutter Health
Sutter East Bay
Medical Foundation
We Plus You

Visit Date: _____ Patient's Name: _____

Date of Birth: _____

Medical Record #:_____

Primary Care Provider:_____ Referred by: _____

Drug Allergies/Sensitivities: _____

Emergency Ph#: _____ Contact Person/Relationship: _____

Confidential Ph#: _____ May we leave a message: ❑ No ❑ Yes

What was the reason for your visit today? _____

_____

What is your occupation? _____

If you are uncomfortable with any question, leave it blank; you can discuss it with your clinician. Thank you!

Review of Symptoms

Please check the box if you are experiencing any of the following symptoms:

❑ Asthma
❑ Anemia
❑ Arthritis/Joint Pain
❑ Autoimmune Disease (Lupus)
❑ Bleeding Disorders
❑ Blood Clots in Lungs or Legs
❑ Heart Attack / Disease
❑ Hepatitis / Liver Disease
❑ High Blood pressure
❑ HIV / AIDS
❑ Infertility
❑ Bowel Problems
❑ Broken Bones
❑ Cancer
❑ Cataracts
❑ Chicken Pox
❑ Depression / Anxiety
❑ Kidney Infections/Stone
❑ Pneumonia / Lung Disease
❑ Rheumatic Fever
❑ Reflux / Hiatal Hernia / Ulcers
❑ Seizures /Convulsions
❑ Diabetes
❑ Eating Disorders
❑ Fibroids
❑ Gallbladder Disease
❑ Glaucoma
❑ Headaches
❑ STD / Chlamydia
❑ Stroke
❑ Tuberculosis
❑ Thyroid Disease
❑ Blood Transfusion

❑ None
❑ Other:_____

Continued>

Surgical History

Surgery/Hospitalization	Date

Gynecologic History

Last Menstrual period: _____

Age Periods began: _____

# of Days of bleeding: _____

# of Days between periods: _____

Any changes to periods: _____

Have you ever had sex: ❑ No ❑ Yes

Are you sexually active currently: ❑ No ❑ Yes

Number of partners (lifetime): _____

Sexual partners are: ❑ Men ❑ Women ❑ Both

Method of contraception: _____

Last pap: _____

Any abnormal pap? (if yes result/when): _____

Follow up procedure?: _____

Exposure to DES in utero: ❑ No ❑ Yes

Gardasil Vaccine: ❑ No ❑ Yes, Year: _____

Colonoscopy: ❑ No ❑ Yes, Date: _____

Results: _____

Last Mammogram: ❑ No ❑ Yes, Date: _____

Results: _____

Bone Density Screening: ❑ No ❑ Yes, Date: _____

Results: _____

Exercise: _____times/week: _____

Calcium/Dairy intake Daily: _____

Medications

Name *Example: Synthroid*	**Dose** *100mcg*	**Frequency** *Daily*	**Reason** *Low thyroid*

Pregnancy History

❑ Never been pregnant

Total Pregnancies:____ Full Term:____ Pre Term (< 37wk):____
Miscarriages:____ Abortions:____ Living Children: _____

Date	**Weeks**	**Delivery Type** (ex. D&C, Vaginal, cesarean)	**Sex**	**Birth Weight of baby**	**Name**	**Delivery location**	**Complications** (ex. high blood pressure, diabetes, depression)

Review of Symptoms

Please check the box if you are experiencing any of the following symptoms:

❑ significant weight loss
❑ significant weight gain
❑ sinus problems
❑ chest pain or pressure
❑ rapid or irregular heartbeat
❑ leg swelling
❑ wheezing
❑ chronic cough
❑ coughing up blood
❑ shortness of breath
❑ frequent diarrhea
❑ nausea/vomiting
❑ blood in stools
❑ enlarged lymph nodes (glands)
❑ involuntary loss of gas/stool
❑ constipation
❑ blood in urine
❑ pain with urination
❑ frequent urination
❑ involuntary urinary loss
❑ abnormal bleeding
❑ painful periods
❑ premenstrual syndrome (PMS)
❑ pelvic or abdominal pain
❑ vaginal dryness
❑ painful intercourse
❑ abnormal vaginal discharge
❑ frequent bruising
❑ moles with growth/change
❑ breast pain
❑ nipple discharge
❑ breast lumps
❑ trouble walking
❑ memory problems
❑ frequent headaches
❑ numbness
❑ dizziness
❑ depression
❑ anxiety
❑ heat or cold intolerance
❑ hair loss
❑ hot flashes

❑ Other: _____

❑ Currently I am experiencing none of the above symptoms

Family Medical History

Mother: ❑ Living ❑ Deceased, Age: ____ Father: ❑ Living ❑ Deceased, Age: ____

Sister(s): ❑ Living ❑ Deceased, Age: ____ Brother(s): ❑ Living ❑ Deceased, Age: ____

Please indicate if there is a family history of any of the following medical illnesses or cancers

Example: Osteoporosis Brother 36 yrs Aunt 44years Grandfather 65 yrs
Cousin 58yrs

	Siblings/ Children (age at diagnosis)	**Mother's side (age at diagnosis)**	**Father's side (age at diagnosis)**
Osteoporosis			
High blood pressure			
High Cholesterol			
Heart Disease/Stroke			
Blood Clots			
Diabetes			
Hepatitis			
HIV/AIDS			
Alcohol/drug problems			
Mental Illness/depression			
Other:			

***Please complete attached Hereditary Cancer Questionnaire about your family cancer history. In effort to provide the best care, we will not address this in detail at your Annual visit but can make a separate appointment to review and discuss this further.**

Social History

❑ Married ❑ Single ❑ Civil Union ❑ Divorced ❑ Widow(er) ❑ Separated ❑ Living with Partner

Sexual Orientation: ❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Transgender ❑ Other: _____

Occupation: _____ Religious Preference: _____

	Current	Former	Never		
Alcohol use	❑	❑	❑	Drinks/wk: _____	Type: _____
Tobacco use	❑	❑	❑	Packs/day: _____	# of years: _____
Drug use	❑	❑	❑	Type: _____	# of years: _____

Do you wear a seat belt? ❑ No ❑ Yes

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

Advance Directive? ❑ No ❑ Yes, Date: _____

Education: ❑ JuniorHS ❑ HS ❑ College ❑ Graduate Education: _____

Signature: _____ Date: _____

Reviewed by: _____ Date: _____