

Please complete before arriving for your appointment. This is part of your medical record and is kept absolutely confidential.



1301 Taylor St
Suite 6-J
Columbia, SC 29201

Date:

New Patient History Form

Name:	SSN:	Age:	Date of Birth:
Primary Care Physician:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Divorce	
Reason for visit:			

Gyneologic History

Age period began:	Date of last menses:	Are menses regular: <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of days between menses:	Number of days bleeding:	Do you have pain with periods <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sexually active: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> heterosexual <input type="checkbox"/> homosexual <input type="checkbox"/> bisexual	
Current Birth Control Method:	What other methods have you used in the past?	Heavy flow/clots: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with a STD: <input type="checkbox"/> Yes <input type="checkbox"/> No	What? When?	Have you been tested for HIV (AIDS) Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Date of last pap:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Have you ever had an abnormal smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	How was it treated?
Date of last mammogram:	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Date of last colon cancer screening:	Date of last bone density study:
Have you had recent bloodwork to check cholesterol, glucose, and thyroid? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Obstetric History

Total Number of pregnancies: _____ Miscarraiges: _____ Abortions: _____ Living Children: _____			
Any complications of pregnancy or delivery:			
Did you have gestational diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No	Preeclampsia? <input type="checkbox"/> Yes <input type="checkbox"/> No	

No.	Birth Date	Male/female	Birth weight	Type of delivery
1				
2				
3				
4				
5				
6				

Current Medications:

(Also include all vitamins, herbs, and any frequently used over the counter medications)

Drug Name:	Dosage:	Prescribed by:	Drug Name:	Dosage	Prescribed by:

_____ I have a Universal Medication Form (attached)

Allergies: (Drug name and reaction)

Drug Name	Reaction	Drug Name	Reaction

Do you have a latex allergy? Yes No

Medical History

Illness	Date	Illness	Date

Surgical History

Surgery	Date	Surgery	Date

Social History

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much?	How many years?
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many drinks/week?	
Do you use street drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No	What type and how often?	
Any history of sexual or physical abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your current occupation?	

Family History

Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased	Cause of death:	Age of death:
Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased	Cause of death:	Age of death:
<input type="checkbox"/> Family History Unknown		
Is there a family history of the following? (Please list affected family members)		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart disease	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blood clots in legs/lungs	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Ovarian Cancer	
<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Mental Illness/depression	
<input type="checkbox"/> Fibroids	<input type="checkbox"/> Endometriosis	

Review of Systems

Please check if you are currently experiencing the symptoms below

Symptom	Y	N	Symptom	Y	N	Symptom	Y	N
Weight loss/gain			Irregular heartbeat			Fatigue		
Constipation/diarrhea			Visual problems			Urinary leakage		
Chest pain			Frequent urination			Difficulty breathing		
Painful urination			Joint/muscle pain			Frequent headaches		
Breast Pain			Depression/anxiety			Breast Discharge		
Hot flashes			Abnormal thirst			Hair loss		