Date:_______________

# WEST END OB/GYN, PC

## NEW PATIENT ENCOUNTER

Welcome to our office. Please take a few minutes to provide us with information to better serve you.

**Name** ______________________________ **Email** ______________________________

**Race** ______________________________ **Hispanic** ☐ **Non-Hispanic** ☐

**Pharmacy #:**________________________ **Primary Care Physician (PCP)**__________**Office**_____

What is the nature of your visit? ☐ Annual exam ☐ Consultation ☐ Other

☐ Problem Visit (please explain) ______________________________________________

How did you learn about this office? ______________________________________________

Please list any **medical problems** that a doctor is treating. (Example: asthma, diabetes, depression, and hypertension) Please include the name of the doctor who cares for you.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Please list any previous **surgery**. (Example: tubal ligation, appendectomy, hysterectomy, colposcopy)

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Please list current **medications** including dosing.

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Please list any **allergies to medications**.

___________________________________

___________________________________

___________________________________

Please list all **other allergies**. (Example: latex, food)

___________________________________

___________________________________

___________________________________

Please check the box below if you have **previously received the Human Papilloma Virus (HPV) injection, also called Gardasil, at another medical facility.**

☐ I have received the HPV vaccination. It was given to me at ______________________________.

(name of facility)

I received a total of (please check box) ☐ **1,** ☐ **2,** ☐ **3 HPV injections.**

Please tell us about any **previous pregnancies.**

☐ Does not apply, I have never been pregnant before.

_________ Total number of times pregnant          __________ Number of vaginal deliveries

_________ Number of miscarriages          __________ Number of C-sections

_________ Number of abortions          __________ Number of living children

Have you ever had any **previous GYN problems?** (Please check box for those that apply)

☐ Abnormal pap's ______________          ☐ Sexually transmitted diseases _____________

☐ Abnormal mammograms          ☐ Problems with menstrual cycle

Are you sexually active? ☐ Yes ☐ No

Do you use birth control? ☐ Yes ☐ No If so, what form: ____________________

Do you have a history of cold sores/fever blisters? ☐ Yes ☐ No

**Family History**: (check history that applies)

| | | |
|---|---|---|
| ☐ Hypertension | ☐ Diabetes | ☐ Heart Disease |
| ☐ Cancer of the colon | ☐ Cancer of the ovary | ☐ Cancer of the uterus |
| ☐ Cancer of the breast | ☐ High cholesterol | ☐ Other __________________________ |

**Social History**: (check history that applies)

Marital Status: ☐ Married, ☐ Divorced, ☐ Single, ☐ Widowed

Are you employed? ☐ Yes ☐ No What occupation? ____________________

Do you smoke or have a history of smoking? ☐Yes ☐ No If so, how much ________and for how long?_____

Do you use alcohol? ☐Yes ☐ No If so, how often? ______________________

Illegal drug use, past or present? ☐Yes ☐ No

Do you wear a seat belt? ☐Yes ☐ No          Do you exercise regularly? ☐Yes ☐ No

Have you ever experienced domestic abuse (physical or emotional)? ☐Yes ☐ No

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**Review of Systems**: (Please check all that apply currently or you still suffer with.)

| | | | |
|---|---|---|---|
| ☐ Heart Palpitations | ☐ Weight Loss | ☐ Weight Gain | ☐ Vision problems |
| ☐ Hearing Problem | ☐ Chest pain | ☐ Pain urinating | ☐ Trouble breathing |
| ☐ Muscle pain/injury | ☐ Fever | ☐ Leaking urine | ☐ Skin problems |
| ☐ Emotional problems | ☐ Cough | ☐ New allergies | ☐ Constipation |
| ☐ Lymph node swelling | ☐ Diarrhea | ☐ Vomiting | ☐ Endocrine problems |

Please explain any checked problems from above. ____________________________________________

_______________________________________________________________________________