Consultants in Women's Healthcare
Washington University Clinical Associates

NEW PATIENT HEALTH HISTORY
(Please Fill Out Completely)

PATIENT NAME:_____ DOB:___/___/_____ TODAY'S DATE:_____

Reason for your visit	**Referring Provider (if applicable)**	**Primary Care Provider**
_____ _____ _____	Name:_____ Phone:_____	Name:_____ Phone:_____ Pharmacy:_____

Would you like a chaperone in the room for your exam (circle one)? Yes / No
What are your pronouns?_____

CURRENT MEDICATIONS
Please list all medications that you are currently taking.

Medication	Dosage	How often?

ALLERGIES
Please list known medication allergies and what happens during a reaction.

Allergy	Reaction

MEDICAL HISTORY
Please circle yes or no for items that apply to you now or in the past.

Anxiety Y / N
Depression Y / N
Eating disorder Y / N
Breast cancer Y / N
Any cancer Y / N
Hereditary clotting disorder Y / N
Blood clots (legs / lungs) Y / N
Blood transfusion Y / N
Tuberculosis Y / N

Diabetes Y / N
Heart disease Y / N
High blood pressure Y / N
High cholesterol Y / N
Kidney disease Y / N
Hepatitis Y / N
Seizures Y / N
Asthma Y / N

Glaucoma Y / N
Sickle cell disease / trait Y / N
Hypothyroid or hyperthyroid Y / N
Uterine abnormality Y / N
Migraines Y / N
Infertility Y / N
Osteoporosis Y / N
Other:_____
_____

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PATIENT NAME:_____ DOB:___/___/_____ TODAY'S DATE:_____

PAST SURGERIES AND HOSPITALIZATIONS

Please date and list all past surgeries and hospitalizations along with the reason.

Date Surgery / Hospitalization Description

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY

Please mark an "X" for any family members who had the condition.

	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Blood Clots in Legs/ Lungs	Blood Clotting Disorders	Problems with Anesthesia	Heart Disease	Diabetes	Osteo-porosis
Mother										
Sister										
Father										
Brother										
Maternal Grand-mother										
Paternal Grand-mother										
Maternal Aunt										
Paternal Aunt										
Maternal Grandfather										
Paternal Grandfather										
Maternal Uncle										
Paternal Uncle										

(Please continue to the next page.)

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PATIENT NAME:_____ DOB:___/___/_____ TODAY'S DATE:_____

OBSTETRIC HISTORY

Please list all past pregnancies and delivery information.

Date of Delivery	# of Weeks of Pregnancy	Vaginal / C-Section	Boy / Girl	First Name	Birth Weight	Complications	Delivering Hospital
		Vaginal / C-Section	Boy / Girl				
		Vaginal / C-Section	Boy / Girl				
		Vaginal / C-Section	Boy / Girl				
		Vaginal / C-Section	Boy / Girl				
		Vaginal / C-Section	Boy / Girl				

SOCIAL HISTORY

Occupation:_____

Marital status: Single____ Married____ Divorced_____ Widowed_____ Partner____

Alcohol usage: Never____ Rarely____ Moderate_____ Daily_____

Tobacco usage: Never____ Previously, but quit____ Interested in quitting____ Current packs/day____

Drug usage: Never____ Type_____ Frequency_____ List all applicable_____

GYNECOLOGIC HISTORY

Date of last menstrual period:_____ Age of first period:____ Age of menopause:____

Menstrual frequency (ex: Every 28-30 days) :_____ How many days bleeding lasts:____

Are you currently experiencing abnormal bleeding? Y N History of sexual/physical abuse? Y N

Are you sexually active? Y N Sexual partners (if applicable): Male Female Both

Pain with periods? Y N History of sexually transmitted infections (ex: Chlamydia)? Y N

Pain with intercourse? Y N Are you using birth control? Y N

If yes, what type of birth control?_____

Date of last Pap smear:_____ Results:_____ Any abnormal Paps:_____

Date of last mammogram:_____ Results:_____ Any abnormal mammograms:_____

Have you ever received a full course of Gardasil (HPV) vaccine? Y N

Date of last colonoscopy (*recommended for patients who are high risk or at least 45 years old*):_____

Date of last bone scan (*recommended for patients who are high risk or at least 65 years old*):_____

(Please continue to the next page.)

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PATIENT NAME:_____ DOB:___/___/_____ TODAY'S DATE:_____

REVIEW OF SYSTEMS
Please circle yes or no for items that apply to you **TODAY**.

General
Fatigue Y / N
Fever Y / N
Weight gain Y / N
Weight loss Y / N
Night sweats Y / N
Sleep disturbance Y / N

Cardiovascular
Chest pain Y / N
Palpitations Y / N

Breast
Breast lump Y / N
Breast pain Y / N
Nipple discharge Y / N

Reproductive
Heavy periods Y / N
Irregular periods Y / N
Missed periods Y / N
Painful periods Y / N
Pain with sex Y / N
Vaginal discharge Y / N
Hot flashes Y / N

Psychiatric
Anxiety Y / N
Depression Y / N
Eating disorder Y / N

Skin
Acne Y / N
Dry skin Y / N
Rash Y / N
Eczema

Respiratory
Shortness of breath Y / N
Cough Y / N
Wheezing Y / N

Neurologic
Headache Y / N
Dizziness Y / N
Seizures Y / N

Gastrointestinal
Nausea Y / N
Vomiting Y / N
Diarrhea Y / N
Constipation Y / N
Abdominal pain Y / N

ENT
Nose bleeds Y / N
Sore throat Y / N

Musculoskeletal
Muscle aches Y / N
Joint pain Y / N
Weakness Y / N

Genitourinary
Frequent urination Y / N
Painful urination Y / N
Loss of urine Y / N

Any concerns or questions about your sexual health that you would like to discuss?

_____
_____
_____
_____

Any concerns or questions about other topics that you would like to discuss?

_____
_____
_____
_____

I attest to the best of my knowledge that the information on these forms is true and accurate.

Patient's signature:_____ Date:_____

Physician's signature:_____ Date:_____