David N. Kells, M.D. *Boojum Obstetrics & Gynecology, P.C.*

New Patient Health History

Patient Name: ____ Age: __________________ Date: ________________________

This questionnaire will help your care provider obtain a large amount of information while still being able to focus on your most important concerns. Please answer all questions as best as you can. All answers will be kept confidential.

Current and Past Medical Problems (for example: anemia, asthma, arthritis, bleeding problems, colitis, cancer, high cholesterol, diabetes, hepatitis, high blood pressure, heart attack, depression, epilepsy, glaucoma, kidney problems, urinary tract infections, incontinence, migraines, HIV, thyroid, pneumonia, Valley Fever)

1. ________________________________ 4. ________________________________

2. ________________________________ 5. ________________________________

3. ________________________________ 6. ________________________________

Operations and date (for example: cesarean section, D&C, hysterectomy, tonsillectomy, appendectomy, gallbladder, breast biopsy)

1. ________________________________ 3. ________________________________

2. ________________________________ 4. ________________________________

Medications (list all medications you currently take including prescriptions, birth control pills, cold medicines, herbal remedies, aspirin, vitamins). Please list medication dosage and frequency.

1. ________________________________ 3. ________________________________

2. ________________________________ 4. ________________________________

Allergies to Medications (all medications that you can not take, or have had a reaction to). Specify type of reaction.

____

____

Social History

Marital status ________________ Highest level of education ____________________ Occupation _________________________

Hobbies ____ Interests ____

1. Do you smoke cigarettes? O Yes O No If yes, how many per day? _________ Do you have a plan to quit? O Yes O No

2. Have you smoked in the past? O Yes O No If yes, how many years and when did you last quit? __________________________

3. Do you drink alcohol? O Yes O No If yes, how many drinks per week? ___________ Do you drink alone? ___________

4. Do you use caffeine? O Yes O No If yes, how much? ____

5. Have you used illegal drugs? O Yes O No If yes, what type and when ____

6. Do you exercise? O Yes O No What type? _________________________________ How often? _______________________

over

7. How much do you weigh? __________________ 5 years ago? _______________ 10 years ago? ____________________

8. Do you have risk factors for AIDS or HIV infection such as intravenous drug use, blood transfusion, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an IV drug user, or have any other reason to believe you may have had AIDS exposure?

____

9. A. Have you ever been physically or sexually touched without your consent or in a manner which you felt was not right?
B. Do you feel safe at home?

____

Health Maintenance

Please list date (year) in which you last had any of these procedures. Indicate results if known.

Complete Physical ___________ PAP smear ___________ Mammogram ____________ Cholesterol screen _______________

Flu shot __________ Tetanus shot __________ Measles, Mumps, Rubella vaccine ___________ Hepatitis B Vaccine ________

Colonoscopy ______________ Chest X-Ray __________ EKG __________________ Bone Densitometry _________

Have you had chicken pox or have you received the varicella vaccine? O Yes O No O Do not know

Gynecologic History

Start date of last menstrual period _____________ Number of days between periods from start to start _____________________

Length of periods __________ Pain with periods O Yes O No Heavy Bleeding O Yes O No Other ____________

____ Age of menopause ________

Number of pregnancies ______ # of children ______ Miscarriages ______ Other (abortions, ectopic, molar pg) ________

Complications of pregnancy ____

Have you ever had an abnormal PAP smear? O Yes O No If yes, what was the diagnosis and how was it treated?

____ Have you received the HPV vaccine? O Yes O No

Have you ever had gonorrhea, chlamydia, pelvic inflammatory disease, Herpes, or syphilis? If yes, when and where were you

treated? ____

Type of birth control _________________________ Breast self exam O Yes O No Estimated mg of daily calcium ________

Pain with intercourse O Yes O No Sexual concerns (libido, orgasm, other) ____

Family History (Blood relatives)

List family members who have had any of these medical problems: Cancer (type), heart attack, high cholesterol, high blood pressure, diabetes, osteoporosis, sickle cell anemia, cystic fibrosis, kidney disease, asthma, thyroid or other medical problem:
Illness: Family Member (s):

____

____

Please list any other concerns you have related to your past or present health history: