RAMAPO VALLEY OB/GYN - PC

NEW PATIENT MEDICAL HISTORY

Date: ____/____/____

Patient Name: ______ Age: ______ DOB: ______
Address: ______ Primary MD: ______
______ Referred By: ______
Occupation: ______ Home Phone: ______
Marital Status: ______ Work Phone: ______
Spouse's Name: ______ Emergency Contact: ______
Children's Name(s) & Age(s): ______ Phone: ______

REASON FOR TODAY'S VISIT ______

ALLERGIES TO MEDICATIONS, DYES OR OTHER SUBSTANCES _____ **NO** _____ **YES**
(If YES, please list name of medication and type of reaction)

______
______

OBSTETRIC & GYNECOLOGIC HISTORY

Age at onset of periods: ______ Frequency: ______ Length of Period: ______
Number of pregnancies: ______ Births: ______ Abortions: ______ Miscarriages: ______
Prolonged or abnormal bleeding: ☐ No ☐ Yes (describe): ______
Leakage of urine: ☐ No ☐ Yes (describe): ______
Pelvic pain: ☐ No ☐ Yes (describe): ______
Abnormal discharge: ☐ No ☐ Yes (describe): ______
History of abnormal pap smear: ☐ No ☐ Yes (describe): ______
Current method of birth control: ______

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS
(Please circle if **YOU** have had problems with or are presently complaining of any of the following:)

1. high blood pressure
2. diabetes
3. cancer
4. heart disease
5. chest pain/tightness
6. frequent urination
7. rheumatic fever
8. asthma
9. change in bowel habits
10. constipation
11. diarrhea
12. blood in stool
13. ulcers
14. abdominal discomfort
15. change in weight
16. hemorrhoids
17. gall bladder disease
18. colitis
19. hepatitis/jaundice
20. thyroid disease
21. headache
22. kidney disease
23. difficulty urinating
24. blood disorders
25. venereal diseases
26. anxiety
27. depression
28. anemia
29. alcohol abuse
30. drug abuse
31. eating disorder
32. eyes
33. ears, nose, mouth, throat
34. musculoskeletal
35. skin
36. other

______
______

(PLEASE CONTINUE ON OTHER SIDE OF PAGE)

PATIENT NAME: **Date:_____/_____/_____**

PLEASE LIST & SUPPLY DATES OF:

Operations: ____

Other Hospitalizations: ____

When was your last:

Pap Smear?		Breast Exam?		Colonscopy?	
Mammogram?		Cholesterol Check?		Bone Density Test?	

FAMILY HISTORY

(Has any member of your family ever had the following:)

Illness			**Which family members?**	**Age when diagnosed**
Cancer:	☐ No	☐ Yes (describe type)		
High blood pressure:	☐ No	☐ Yes		
Heart disease:	☐ No	☐ Yes		
Diabetes:	☐ No	☐ Yes		
Stroke:	☐ No	☐ Yes		
Bleeding diseases:	☐ No	☐ Yes		
Other:				

MEDICATIONS

(Please list any prescription medicines you take on a regular basis:)

Drug Name	**Dose**	**Drug Name**	**Dose**

PREVENTION

Do you smoke cigarettes?	☐ No	☐ Yes	If yes, packs per day:
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, drinks per week:
Do you drink coffee or tea?	☐ No	☐ Yes	If yes, cups per day:
Do you use recreational drugs (marijuana, cocaine, crack, etc.)?	☐ No	☐ Yes	If yes, list type and frequency:
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain:
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	
Do you ever feel afraid of your partner?	☐ No	☐ Yes	

PATIENT SIGNATURE:______________________________ **Date:_____/_____/_____**