THE QUEEN'S HEALTH CARE CENTERS

NEW PATIENT INFORMATION

NAME	AGE	BEST TEL # TO CONTACT YOU	REFERRED BY
REASON FOR VISIT			**PRIMARY CARE PHYSICIAN**

OBSTETRIC HISTORY

NO. OF PREGNANCIES	NO. OF ABORTIONS	NO. OF MISCARRIAGES	NO. OF LIVING CHILDREN

MENSTRUAL HISTORY (If in menopause, skip to next section)

DATE OF LAST MENSTRUAL PERIOD	AGE WHEN FIRST PERIOD BEGAN	NO. OF DAYS BETWEEN PERIODS	HOW MANY DAYS DO YOU BLEED?	NO. OF TAMPONS / PADS ON HEAVIEST DAY	ANY SIGNIFICANT CRAMPS?

MENOPAUSE HISTORY

YEAR MENOPAUSE BEGAN	ANY BLEEDING SINCE MENOPAUSE?	DO YOU HAVE ANY PROBLEMS WITH ANY OF THE FOLLOWING:	HORMONES TAKEN
		☐ vaginal dryness ☐ hot flashes ☐ urination ☐ bowel movements	

GENERAL GYNECOLOGICAL HISTORY

ANY ABNORMAL PAP SMEARS?	DATE LAST PAP SMEAR	WHERE	ANY ABNORMAL MAMMOGRAMS?	DATE OF LAST MAMMOGRAM	WHERE WERE TESTS DONE?
☐ Yes ☐ No			☐ Yes ☐ No		

SEXUALLY ACTIVE?	USING CONTRACEPTION? (IF YES, WHAT METHOD?)	PAIN OR BLEEDING AFTER SEX?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

HISTORY OF PELVIC INFECTIONS OR STD'S	HISTORY OF IUD USE?	SYMPTOMS OF VAGINAL INFECTION / DISCHARGE?	SYMPTOMS OF BLADDER INFECTION?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you have any problems or concerns with any non-gynecologic problems today? ☐ Yes ☐ No

HAVE YOU HAD A BONE DENSITY DONE?	WHEN (DATE):	WHERE WERE TESTS DONE?

GENERAL MEDICAL HISTORY

Please check any of the following problems you have had:

☐ heart problems ☐ liver disorders ☐ thyroid disorder ☐ high cholesterol ☐ changes in weight
☐ asthma or lung problems ☐ kidney or bladder disorders ☐ high blood pressure ☐ hepatitis ☐ loss of bladder control
☐ anxiety or nervous problems ☐ sexually transmitted disease ☐ other _____ ☐ bleeding disorder ☐ diabetes
☐ yes ☐ no Blood transfusion?

Hospitalizations or Surgeries

Reason for hospitalization or surgery — Date

_____ _____
_____ _____
_____ _____

List drug allergies — Reaction — List of medications now taking

_____ _____
_____ _____
_____ _____

Family history

☐ ovarian cancer ☐ breast cancer ☐ stroke ☐ thyroid disease ☐ bleeding disorder
☐ uterine cancer ☐ high blood pressure ☐ hepatitis ☐ other serious illnesses
☐ cervical cancer ☐ heart disease ☐ kidney disease ☐ osteoporosis ☐ diabetes
☐ colon cancer ☐ Other: _____

MISCELLANEOUS

Do you smoke? ☐ Yes ☐ No Ever? ☐ Yes ☐ No No. of packs a day _____ How long? _____	Do you exercise regularly? ☐ Yes ☐ No How often? _____	Do you drink alcohol? ☐ Yes ☐ No How much _____

Do you take drugs? ☐ Yes ☐ No	Contact with blood / body fluids at work? ☐ Yes ☐ No	History of abuse now or as a child? ☐ Yes ☐ No

MARITAL STATUS (CHECK ONE) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	OCCUPATION