**Azalea Gynecology • 1814 New Hanover Medical Park Drive • Wilmington, NC 28403**

## NEW PATIENT HISTORY

**Allergies:**

Name: _____ Age: _____Birthdate: ____/____/____ Today's Date: ____/____/____

SSN: _____ Primary Care Physician: _____ Specialist Physician: _____

### Patient & Family History:

| | Patient | Father | Mother | Sibling | Child | MGM/GF | | PGM/GF | |
|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Asthma | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Bleeding disorder | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Epilepsy/Seizures | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| High Cholesterol | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Heart disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| High blood pressure | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Kidney disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Mental illness | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Migraine | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Osteoporosis | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Thyroid disease | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| Neurologic disorders | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |

(Key: MGM - mother's mother PGM - father's mother MGF - mother's father PGF - father's father)

**Other:** _____

**Surgeries:** _____

**Hospitalizations:** _____

### Social History:

Tobacco use ❑ No ❑ Yes _____ Alcohol/Drug use ❑ No ❑ Yes _____

Sexual Abuse ❑ No ❑ Yes _____ Emotional Abuse ❑ No ❑ Yes _____ Physical Abuse ❑ No ❑ Yes _____

Diet (type/restrictions)_____ Exercise ❑ No ❑ Yes _____ Seat Belt Use ❑ No ❑ Yes Sunscreen use ❑ No ❑ Yes

**OB-GYN History:** LMP (1st day of last period) ____/____/____ Length of Menstrual Cycle (# of days from one cycle to next) _____

How long period lasts? _____ Menstrual Irregularities _____

STD's ❑ Yes ❑ No Type _____ Abnormal paps ❑ Yes ❑ No Type _____

Infertility ❑ Yes ❑ No Abnormal vaginal discharge ❑ Yes ❑ No Abnormal vaginal bleeding ❑ Yes ❑ No

_____

Pregnancies: Total # pregnancies ____ # miscarriages ____ # abortions ____ # living children ____

| Date | Gest Age | Hrs Labor | Induced? | Type Del | Alive/Dead | Baby's Wt | Sex | Complications (pregnancy, labor, delivery, postpartum) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |

**Leave this section blank to be completed by clinical staff:**

**Last Pap:** Date_____ Results _____

**Mammogram:** Date _____ Loc _____ Results _____

**Colorectal Screening:** Date _____ Results _____

**Type of Birth Control:** _____

**BSE:** ❑ Yes ❑ No FamHx Br Ca _____

**Bone Density:** Date _____ Results _____

**Immunizations:** ❑ Tetanus ❑ Rubella ❑ Hep B ❑ Gardasil

**Allergies:** ❑ None _____

**Current Prescription Medication:** _____

OTC's: _____

MVI: _____ Herbals: _____

**Chief Complaint:** _____

## REVIEW OF SYSTEMS

**Allergies:**

Name: _____ Age: _____Birthdate: _____/_____/_____ Today's Date: _____/_____/_____

****Please check any positive answers for symptoms persistent throughout the past year. Check the negative box if none are present.**

1. Constitutional ❑ Negative ❑ Weight loss ❑ Weight gain ❑ Fever ❑ Fatigue
   Other _____

2. Eyes ❑ Negative ❑ Vision change ❑ Glasses/contacts
   Other _____

3. Ears/Nose/Throat/Mouth ❑ Negative ❑ Ulcers ❑ Sinusitis ❑ Ringing in ears ❑ Headache
   Other _____

4. Cardiovascular ❑ Negative ❑ Shortness of breath lying down ❑ Chest pain ❑ Dizziness ❑ Swelling ❑ Palpitations
   Other _____

5. Respiratory ❑ Negative ❑ Wheezing ❑ Cough ❑ Coughing up blood ❑ Shortness of breath

6. Gastrointestinal ❑ Negative ❑ Diarrhea ❑ Bloody Stools ❑ Nausea ❑ Vomiting ❑ Pain ❑ Gas ❑ Constipation
   Other _____

7. Genitourinary ❑ Negative ❑ Blood in urine ❑ Difficulty urinating ❑ Urgency ❑ Frequency ❑ Incomplete emptying
   ❑ Abnormal vaginal bleeding ❑ Incontinence ❑ Pain during sex ❑ Abnormal vaginal discharge
   Other _____

8. Musculoskeletal ❑ Negative ❑ Muscle weakness Other _____

9. Skin/Breast ❑ Negative ❑ Breast pain ❑ Discharge ❑ Masses ❑ Rash ❑ Ulcers ❑ Skin changes
   Other _____

10. Neurological ❑ Negative ❑ Fainting ❑ Seizures ❑ Numbness ❑ Trouble Walking
    Other _____

11. Psychiatric ❑ Negative ❑ Depression ❑ Anxiety ❑ Panic disorder ❑ Crying ❑ Mood swings
    Other _____

12. Endocrine ❑ Negative ❑ Diabetes ❑ Hypothyroid ❑ Hyperthyroid ❑ Hair loss ❑ Hot flashes ❑ Night sweats
    Other _____

13. Hematology/Lymphatics ❑ Negative ❑ Bruises easily ❑ Bleeds easily ❑ Anemia ❑ Enlarged lymph nodes
    Other _____

14. Allergies ❑ Negative Other _____