The Hill Ob-Gyn Associates, P.C. New Patient Review of Systems

Name: ________________________ Date of Birth: ______________

Address: ____

Employer: ________________________________ Profession: ________________

Phone: 1- Home: ( ) 2: work: ( ) Marital Status:

History	Your Self		Your Family		Explain
General History	Yes	NO	Yes	NO	
Allergies					
Back injury					
Cancer					
Diabetes					
Gastro-intestinal Disease					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Liver disease					
Lung disease					
Mental Disease					
Neurological disorders					
Operations					
Thyroid disease					
Tuberculosis					

Gynecologic History

	Yes	No		Yes	No		Yes	No
Fibroids			Irregular bleeding			Pain with urination		
Endometriosis			Heavy bleeding			Urgency/frequency		
Pelvic Pain			Bleeding between periods			Blood in urine		
Pain with intercourse			Pain with periods			Blood in stools		
Pelvic Infection			Abnormal discharge			Pain with defecation		
Sexually transmitted diseases			Perineal itching			Infertility		
Venereal warts			Perineal burning			Infertility Drugs		
Herpes			Stress Urinary Incontinence			Insemination		

Menstrual History: Date of last period:

Age Started	Interval	Duration	Pads Per Day	Clots	Emotional Changes	Breast Pain	Swelling

Birth control Method used: ____________________ Sexual Orientation: ____________

Age of First Intercourse: _____________ Do you like to be checked for sexually transmitted diseases? _______________________

Gynecologic surgery: Please list operations and dates below**.**

Date	Operation	Date	Operation

Obstetric History:

Number of Pregnancies:-	Full Term:-	Premature:-	Miscarriages:-	Number of Children:-

List of pregnancies (Start with your first):

Year	Weeks	Vaginal	Cesarean Section	Sex	Weight	Complication

Medications: List all medications you are taking (prescription and over the counter):

1:	2:	3:	4:
5:	6:	7:	8:

Allergies: List any medications you are allergic to and describe reaction:

Medication	Type of reaction	Medication	Type of reaction

Date of last Pap smear: ____________________ Result: ______________________________
Date of last Mammogram: _________________ Result: ______________________________
Date of last bone density study: _____________ Result: ______________________________
Do you take any Extra? Calcium: ______________________ Vitamins: __________________ Iron: __________________
Do you do breast exams: ________________ **Do you smoke**: _____________ Number of cigarettes per day: _______________
Other habits (please list amounts): Coffee: ________________ Alcohol: ___________________ Sodas: ________________
Street drugs: ____ Other: ______________________________
History of blood transfusions: ____
List any medical conditions for which you are receiving care: - 1: ____________________________
2: -____ 3: ____
4: ____ 5: ____

Immunizations: MMR: Varicella: Tetanus: Hepatitis B: HPV:
Who referred you to this office: ____
Name of you primary physician: ____
Do you like us to send a letter and/or send results of pap smears, mammograms, lab work or any other studies to your primary or referring physician: ____
Please explain reason for your visit and list any questions you like to discus with a physician or a nurse:

____
____
____
____
____
____
____

Date: ____________________________ Signature: ____