

NEW BEGINNINGS OB/GYN

336 N. BABCOCK ST. STE 101

MELBOURNE, FL 32935

NAME: _____

DATE: ____/____/____

Date of Birth: ____/____/____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN

LIST ALLERGIES TO MEDICATIONS/SUBSTANCES

YOUR GYN HISTORY

	YES	NO		YES	NO
Do you use Birth Control			Nuvaring		
Condoms			Orthoevra		
Depo Provera			Implanon		
Diaphragm			Tubal Ligation		
IUD-Kind			Vasectomy		
Mirena			Natural family Planning		
Paraguard			Contraceptive Foam/Jelly		
Date Inserted: _____			Blood Clots with periods		
Birth Control Pill			Bleeding between periods		
Name: _____			Pain with periods		
Menopause			Pelvic pain at other times		
What age: _____			Other		
Sexually Transmitted Infection			Sexually Active		
GC/Chlamydia			Age started: _____		
Herpes			Number of Partners: _____		
Trichomonas					
Other					

YOUR OBSTETRICAL HISTORY

Number of Pregnancy _____					
Date	Weight	Gender	Mode of Delivery	Location	Complications

What age did you have your first period: _____

How many days are there from start of period to start of next period _____ days

How long does your period last: _____ days

Flow: Light Med Heavy

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FILL OUT FOR ANNUALS ONLY

Review of System

Please Check (x) if any of the following applies to you now

Constitutional	Genitourinary
Weight Loss <input type="checkbox"/>	Urgency of Urination <input type="checkbox"/>
Weight Gain <input type="checkbox"/>	Frequency of Urination <input type="checkbox"/>
Fever <input type="checkbox"/>	Pain with Urination <input type="checkbox"/>
Fatigue <input type="checkbox"/>	Night Time Urination <input type="checkbox"/>
Night Sweats <input type="checkbox"/>	Losing Urine <input type="checkbox"/>
Hot Flash <input type="checkbox"/>	Blood in Urine <input type="checkbox"/>
Eyes <input type="checkbox"/>	Decreased sex drive <input type="checkbox"/>
Double Vision <input type="checkbox"/>	Painful Intercourse <input type="checkbox"/>
Vision Change <input type="checkbox"/>	Possible Pregnancy <input type="checkbox"/>
Hent	Genital Sores <input type="checkbox"/>
Headaches <input type="checkbox"/>	Vaginal Discharge <input type="checkbox"/>
Dizziness <input type="checkbox"/>	Skin
Sore Throat <input type="checkbox"/>	Rash <input type="checkbox"/>
Sinus Pain <input type="checkbox"/>	Itching <input type="checkbox"/>
Nose Bleeding <input type="checkbox"/>	Skin Dryness <input type="checkbox"/>
Thyroid Mass <input type="checkbox"/>	Skin Lesions <input type="checkbox"/>
Neck Pain <input type="checkbox"/>	Changes to Lesions or Moles <input type="checkbox"/>
Breast	Acne <input type="checkbox"/>
Lumps <input type="checkbox"/>	Neurological
Tenderness <input type="checkbox"/>	Muscular Weakness <input type="checkbox"/>
Swelling <input type="checkbox"/>	Numbness or Tingling <input type="checkbox"/>
Discharge <input type="checkbox"/>	Difficulty Concentrating <input type="checkbox"/>
Pain in Breast <input type="checkbox"/>	Memory Difficulties <input type="checkbox"/>
Abnormal Changes in Breast <input type="checkbox"/>	Speech Difficulties <input type="checkbox"/>
Cardiovascular	Seizures <input type="checkbox"/>
Chest Pain <input type="checkbox"/>	Loss of Balance <input type="checkbox"/>
Irregular Heart Beats <input type="checkbox"/>	Musculoskeletal <input type="checkbox"/>
Rapid Heart Beats <input type="checkbox"/>	Joint Pain or Swelling <input type="checkbox"/>
Fainting <input type="checkbox"/>	Muscle Pain <input type="checkbox"/>
Swelling of Legs <input type="checkbox"/>	Back Pain <input type="checkbox"/>
Varicose Veins <input type="checkbox"/>	Endocrine
Respiratory <input type="checkbox"/>	Loss of Hair <input type="checkbox"/>
Wheezing <input type="checkbox"/>	Difficulty Tolerating Cold <input type="checkbox"/>
Cough <input type="checkbox"/>	Difficulty Tolerating Heat <input type="checkbox"/>
Shortness of Breath <input type="checkbox"/>	Psychiatric <input type="checkbox"/>
Spitting up Blood <input type="checkbox"/>	Anxiety <input type="checkbox"/>
Gastrointestinal	Depression <input type="checkbox"/>
Nausea <input type="checkbox"/>	Impulsive Behavior <input type="checkbox"/>
Vomiting <input type="checkbox"/>	Suicidal Thoughts <input type="checkbox"/>
Diarrhea <input type="checkbox"/>	Excessive Anger <input type="checkbox"/>
Constipation <input type="checkbox"/>	Mood Swings <input type="checkbox"/>
Abdominal Pain <input type="checkbox"/>	Emotional Abuse <input type="checkbox"/>
Bloody/Black Stool <input type="checkbox"/>	Physical Abuse <input type="checkbox"/>
Hemorrhoids <input type="checkbox"/>	Sexual Abuse <input type="checkbox"/>
Jaundice <input type="checkbox"/>	Allergic/Immunologic
Hematologic/Lymphatic	Frequent Illness <input type="checkbox"/>
Bruises Frequently or easily <input type="checkbox"/>	Seasonal Allergies <input type="checkbox"/>
Cuts Do Not Stop Bleeding <input type="checkbox"/>	Other <input type="checkbox"/>
Enlarge Lymph Nodes <input type="checkbox"/>	1 <input type="checkbox"/>
	2 <input type="checkbox"/>
	3 <input type="checkbox"/>

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CHECK IF YOUR BLOOD RELATIVES HAVE HAD

MAJOR ILLNESSES

(If your answer is yes please select Mother, Father or other)

	YES	NO	Mother	Father	Other
Anxiety					
Arthritis					
Asthma					
Blood Transfusions					
Bowel Disorder					
Migraine Headache					
Cancer (what type?)					
Breast					
Colon					
Ovarian					
Cervical					
Uterine					
Other					
Chronic Lung Disease					
Deep vein thrombosis/Pulmonary embolism					
Depression					
Hepatitis I Liver disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Kidney Stones					
Migraine Headaches					
Osteoporosis/Osteopenia					
Rheumatic Fever					
Seizure Disorder					
Stroke					
Tuberculosis					
Thyroid Disease					
Ulcers					
Diabetes					
Glaucoma					
Heart Disease					