NEW BEGINNINGS OB/GYN

336 N. BABCOCK ST. STE 101
MELBOURNE, FL 32935

MEDICAL HISTORY

NAME:_____ DATE:____/___/___ Date of Birth:___/____/____

Primary care physician:_____ Referred by: _____

Last Menstrual Period: ____/____/_____ AGE:_____

Reason for visit: ☐ Routine Visit ☐ Problem

Describe Problem:_____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEM IN THE PAST

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

WHEN WAS YOUR LAST TEST OR IMMUNIZATION

	DATE		DATE
Last PAP Smear		Gardisil	
Mammogram		Flu Shot	
Colonoscopy/Sigmoidoscopy		Pneumovox	
Bone Density		Other	

PLEASE LIST ANY OPERATION OR HOSPITALIZATIONS YOU HAVE HAD

SURGERY/REASON	DATE	SURGERY/REASON	DATE

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

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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 vien 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					