

## Santa Fe OB/GYN New Patient History

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Who are you seeing today?  Dr. Lynore Martinez  Jennifer Stauss, CNP

Do you have any of the following medical problems?

Diabetes  Heart disease  
 Asthma  Arthritis  
 Hypertension  Other \_\_\_\_\_  
 Personal history of Cancer \_\_\_\_\_  
 If yes, type \_\_\_\_\_

Have you ever had surgery?  No  Yes

If yes, please fill in the following:

Date of Surgery:	Type of surgery:	Indication for surgery:

Do you have any family history of medical problems?  No  Yes

Please include diabetes, high blood pressure, heart disease, cancer

If yes, please fill in the following:

Type of medical problem	Family member (mother, father, sibling)

Do you smoke cigarettes?  No  Yes, \_\_\_\_\_ cigarettes/day

Do you drink alcoholic beverages?  No  Yes, \_\_\_\_\_ drinks/week

Do you use nonprescription drugs such as marijuana, cocaine, heroin, methamphetamine?

No  Yes Type and frequency \_\_\_\_\_  
 Do you exercise?  No  Yes, \_\_\_\_\_ times per week

Are you allergic to any medications?  No  Yes

If yes, please fill in the following:

Medication causing allergy	Reaction to medication, i.e. shortness of breath, rash, hives, etc.

Please let us know about any medications you are currently taking:

Medication	Dosage	Indication for use	Prescribing doctor (please place a check mark here if we prescribe this medication for you)

(please turn over and fill out information on back of sheet)

Have you been pregnant before? \_\_\_\_\_ No \_\_\_\_\_ Yes  
 If yes, please fill out the following information:

Year	Miscarriage, vaginal delivery, or C-section	# of weeks at delivery	Dr/Hospital	Problems

Are you currently attempting to become pregnant or do you desire pregnancy?

\_\_\_\_\_ No \_\_\_\_\_ Yes

Do you think you are pregnant now?

\_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, have you done a pregnancy test?

\_\_\_\_\_ No \_\_\_\_\_ Yes

**GYNECOLOGIC HISTORY:**

What was the first day of your last normal menstrual period? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Are you having any problems with your menstrual cycle? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, what is the problem, i.e., very heavy, irregular cycle, breakthrough bleeding, etc.

\_\_\_\_\_

Are you currently sexually active?

\_\_\_\_\_ No \_\_\_\_\_ Yes

What is your current method of birth control? \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_

When was your last mammogram (if >=35yo)? \_\_\_\_\_

If >50 yrs, have you had a colonoscopy?

\_\_\_\_\_ No \_\_\_\_\_ Yes

If >50 yrs., have you had a bone density test?

\_\_\_\_\_ No \_\_\_\_\_ Yes

**REVIEW OF SYSTEMS:**

Do you have any of the following?

(Please check yes or no)

- 1) Fever, chills or weight loss? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 2) Blurred or double vision, cataracts or glaucoma? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 3) Hearing loss or ringing or itching of the ears? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 4) Nasal congestion or nose bleeds? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 5) Chest pain or palpitations? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 6) Nausea, vomiting, diarrhea or abdominal pain? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 7) Urinary frequency, urgency or pain? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 8) Urinary incontinence or blood in the urine? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 9) Painful or swollen joints? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 10) Headache, loss of consciousness or seizure? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 11) Signs of depression? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 12) Skin rash or lesion? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 13) Heat or cold intolerance, change to hair or nails? \_\_\_\_\_ No \_\_\_\_\_ Yes
- 14) Palpable lymph nodes or easy bruising? \_\_\_\_\_ No \_\_\_\_\_ Yes

\_\_\_\_\_ I have included all pertinent information regarding my health history.

\_\_\_\_\_ I have additional health issues that were not addressed on this form.

\_\_\_\_\_  
 Signature of patient (or parent if patient is a minor)

\_\_\_\_\_  
 Date

---