

**SANTA FE OB/GYN NEW PATIENT HISTORY**

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Are you allergic to any medication?** \_\_\_No \_\_\_Yes

Do you have any of the following medical problems?

- \_\_\_Diabetes
- \_\_\_Heart disease
- \_\_\_Arthritis
- \_\_\_Thyroid problem
- \_\_\_Asthma
- \_\_\_History of abnormal pap smear
- \_\_\_High Blood Pressure
- \_\_\_Personal history of cancer

If yes, type \_\_\_\_\_

Have you ever had surgery?

\_\_\_yes \_\_\_no

If yes, please list, beginning with most recent below

Date \_\_\_\_\_ Type of surgery \_\_\_\_\_

Date \_\_\_\_\_ Type of surgery \_\_\_\_\_

Date \_\_\_\_\_ Type of surgery \_\_\_\_\_

Do you have any other medical problems not listed above? \_\_\_\_\_

Family medical history, please think back as far as grandparents, and indicate if on mother's or father's side of your family.

Type of medical problem \_\_\_\_\_, Family member \_\_\_\_\_  
\_\_\_\_\_, Family member \_\_\_\_\_  
\_\_\_\_\_, Family member \_\_\_\_\_  
\_\_\_\_\_, Family member \_\_\_\_\_

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 taking any medications? If yes list below:

Medication	Dose	Prescribing doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently trying to become pregnant? \_\_\_No \_\_\_Yes

If not what is your birth control method? \_\_\_\_\_ Please include condoms, tubal ligation or vasectomy.

What was the first day of your last menstrual period \_\_\_\_\_  
Are you having any problems with your periods? \_\_\_\_Yes \_\_\_\_No  
If yes, what kind of problem? \_\_\_\_\_

Are you currently sexually active? \_\_\_\_No \_\_\_\_Yes  
When was your last pap smear? \_\_\_\_\_  
When was your last mammogram? \_\_\_\_\_ (if >= 35 years old)  
If > 50 years old, have you had a colonoscopy? \_\_\_\_No \_\_\_\_Yes  
If > 50 years old, have you had a bone density test? \_\_\_\_No \_\_\_\_Yes

**REVIEW OF SYSTEMS**

1 Fever, chills, or weight loss? \_\_\_\_No \_\_\_\_Yes  
2 Hearing loss or ringing or itching of the ears? \_\_\_\_No \_\_\_\_Yes  
2 blurred or double vision, cataracts or glaucoma? \_\_\_\_No \_\_\_\_Yes  
3 Nasal congestion or nose bleeds? \_\_\_\_No \_\_\_\_Yes  
4 Chest pain or palpitations? \_\_\_\_No \_\_\_\_Yes  
5 Nausea, vomiting diarrhea or abdominal pain? \_\_\_\_No \_\_\_\_Yes  
6 Urinary frequency, urgency, or pain? \_\_\_\_No \_\_\_\_Yes  
7 Urinary incontinence or blood in the urine? \_\_\_\_No \_\_\_\_Yes  
8 Painful or swollen joints? \_\_\_\_No \_\_\_\_Yes  
9 Headache, loss of consciousness, or seizure? \_\_\_\_No \_\_\_\_Yes  
10 Signs of depression? \_\_\_\_No \_\_\_\_Yes  
11 Skin rash or lesion? \_\_\_\_No \_\_\_\_Yes  
12 Heat or cold intolerance, change to hair or nails \_\_\_\_No \_\_\_\_Yes  
14 Swollen lymph nodes or easy bruising? \_\_\_\_No \_\_\_\_Yes

**I HAVE INCLUDED ALL PERTINENT INFORMATION REGARDING MY  
HEALTH HISTORY \_\_\_\_no \_\_\_\_yes**

**I HAVE ADDITIONAL HEALTH ISSUES NOT ADDRESSED ON FORM  
\_\_\_\_no \_\_\_\_yes**

**SIGNATURE OF PATIENT** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(or parent if patient is a minor)