GALLATIN WOMEN'S CENTER, PC

NEW PATIENT HISTORY

Today's date: _____/_____/_____

Patient Name _____ Age: _____ Race: _____

Referred By _____

Reason for Seeing Appointment or Concerns You Wish to Discuss_____

_____

MEDICAL HISTORY

Please answer the following questions and check appropriate box.

FOR PHYSICIAN USE ONLY

DO YOU HAVE or HAVE ANY OF YOUR FAMILY HAD:

	YES	NO	FAMILY
1. Headaches or a Nervous Disorder	☐	☐	☐
2. Thyroid Problem	☐	☐	☐
3. Heart Condition or High Blood Pressure	☐	☐	☐
4. Lung Disorder	☐	☐	☐
5. Breast Problems	☐	☐	☐
6. Jaundice, Hepatitis or Liver Disorder	☐	☐	☐
7. Stomach, Bowel or Gallbladder Issues	☐	☐	☐
8. Kidney or Bladder Problems	☐	☐	☐
9. Female or Sexual Problems	☐	☐	☐
10. Allergies or Drug Sensitivities	☐	☐	☐
11. Anemia or Blood Disorders	☐	☐	☐
12. Diabetes	☐	☐	☐
13. Cancer	☐	☐	☐
14. Birth Defects or Inherited Diseases	☐	☐	☐
15. Other Medical Problems	☐	☐	☐
Do you Smoke?	☐	☐	☐
Are you sexually active?	☐	☐	☐

HOSPITALIZATIONS

Please list operations or other serious illnesses requiring hospitalization.

Month/Year	Illness/Operation	Complication? Yes or No

PREGNANCY HISTORY

Please list the number of: Pregnancies _____ Full Term _____ Premature Births _____ Miscarriages _____ Abortions _____ Living Children _____

Born Mo/Day/Year	Sex (M/F)	Normal or C/S	No. of Weeks Pregnant	Birth Weight	Complications Y/N
1.					
2.					
3.					
4.					
5.					