

*Women Physicians ObGyn Medical Group*

New Patient – Young Adult History Form - revised 10/04

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date \_\_\_\_\_

School \_\_\_\_\_ Reason for today's visit \_\_\_\_\_

Have you had: (please check)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Acne                     | <input type="checkbox"/> Allergies/Hayfever        | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Bladder/Kidney Infection | <input type="checkbox"/> Blood disorder            | <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Depression                | <input type="checkbox"/> Diábetes            | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Emotional Disorder       | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Stomach Problems          | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Other _____              |  |  |  |

Immunizations: (please indicate date of last dose)

Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Rubella \_\_\_\_\_

Tetanus \_\_\_\_\_ Varicella (Chicken Pox) \_\_\_\_\_

Age at 1<sup>st</sup> period \_\_\_\_\_ First day of last period \_\_\_\_\_ Duration of flow \_\_\_\_\_

How often do you have periods? \_\_\_\_\_ Do you have cramps? Yes No

Do you take medications for cramps? Yes No Name of medication \_\_\_\_\_

Have you had a Pap smear? Yes No Any abnormal Paps? Yes No

Surgeries \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Serious Injuries \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Current Medications \_\_\_\_\_

Over-the-Counter Medications \_\_\_\_\_

Herbs & Vitamins \_\_\_\_\_

Family History: (if yes, list who)

Blood Clots \_\_\_\_\_ Blood Disorders \_\_\_\_\_

Cancer \_\_\_\_\_ Depression \_\_\_\_\_

Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_

High Cholesterol \_\_\_\_\_ Stroke \_\_\_\_\_

Other \_\_\_\_\_