Weill Cornell Medicine
Primary Care

Location:

NEW PATIENT MEDICAL HISTORY FORM

Name: ______________________ **Date:** ______________

Primary Care Provider: ______________________ **DOB:** ______________ **Age:** ____

Who referred you?: ______________________

Reason for visit: ______________________

MENSTRUAL HISTORY

Date of last menstrual period:

Age at first period: ________

My period usually occurs every ________ ◯ days ◯ weeks

My period usually lasts ________ days

My period usually is ◯ painful ◯ not painful   My period usually is ◯ heavy ◯ not heavy

My period is unusual or irregular as described here: ______________________

Age at menopause: ________

If you are menopausal, are you on hormone replacement therapy? ◯ yes ◯ no

Type: ______________________ Dose: ______________________

GYNECOLOGIC HISTORY

Date of last pap smear: ________

Have you every had abnormal pap smears? ◯ yes ◯ no

If yes, please detail year and treatment given: ______________________

Date of most recent mammogram: ________

Have you every had an abnormal mammogram? ◯ yes ◯ no

If yes, please detail: ______________________

Have you ever required a breast sonogram? ◯ yes ◯ no

Do you perform monthly breast self exams? ◯ yes ◯ no

If yes, have you ever felt a lump or irregularity: ______________________

Have you had any of the following gynecologic infections?

- ☐ none
- ☐ bacterial vaginosis (gardnerella)
- ☐ chlamydia
- ☐ genital warts (HPV)
- ☐ gonorrhea
- ☐ herpes
- ☐ trichomonas
- ☐ syphilis
- ☐ yeast

If yes, please detail year and treatment given: ______________________

Have you ever had an infection in your Fallopian tubes or ovaries (PID)? ◯ yes ◯ no

If yes, please detail year and treatment given: ______________________

Have you had fibroids? ◯ yes ◯ no

If yes, treatment given: ______________________

Have you had ovarian cysts? ◯ yes ◯ no

If yes, please detail year and treatment given: ______________________

Are you currently having sex? ◯ yes ◯ no

If so, are you experiencing any problems? ______________________

My current methods of preventing pregnancy is: ______________________

Other methods of contraception that you have used:

- ☐ birth control pills
- ☐ IUD
- ☐ condoms
- ☐ spermacide
- ☐ depo-provera
- ☐ norplant
- ☐ diaphragm
- ☐ natural family planning (rhythm)
- ☐ withdrawal
- ☐ cervical cap

Have you had any problems with these methods: ______________________

Are you aware that condoms help prevent sexually transmitted diseases? ◯ yes ◯ no

When were you last tested for HIV? ______________________

Would you like to be tested for HIV today? ◯ yes ◯ no

OBSTETRICAL HISTORY

Total number of pregnancies ☐ Vaginal deliveries ☐ C-sections ☐ Miscarriages ☐ Abortions ☐ Ectopics ☐

Pregnancy complications: ______________________

MEDICAL CONDITIONS

(Either now or in the past/Detail below with year of diagnosis and treatment given)

- ☐ anemia
- ☐ anxiety/depression
- ☐ bleeding disorder
- ☐ breast disease
- ☐ cancer (specify)
- ☐ cataracts
- ☐ diabetes
- ☐ gallstones
- ☐ heart attack
- ☐ hemorrhoids
- ☐ other:
- ☐ hepatitis/jaundice/liver disease
- ☐ hiatal hernia
- ☐ hypertension
- ☐ incontinence
- ☐ irritable bowel
- ☐ kidney stones
- ☐ frequent bladder infections
- ☐ lung disease/asthma
- ☐ migraines/headaches
- ☐ mitral valve prolapse/heart murur
- ☐ pneumonia/bronchitis
- ☐ seizure disorder/epilepsy
- ☐ sexual problems
- ☐ sickle cell/carrier
- ☐ stroke
- ☐ thalassemia
- ☐ thrombotoic disorder (blood clot)
- ☐ thyroid (high/low)
- ☐ urinary incontinence
- ☐ varicose veins/thrombophlebitis

Detail: ______________________

SURGICAL HISTORY

	Name of Procedure	Date of Procedure	Reason for Procedure
1			
2			
3			
4			

CURRENT MEDICATIONS

	Name of Medication	Dosage	How Often Taken
1			
2			
3			
4			
5			
6			

Are you allergic to any medications? ◯ yes ◯ no

If yes, medication and reaction: ______________________________

FAMILY HISTORY

◯ yes ◯ no Breast cancer

◯ yes ◯ no Ovarian cancer

◯ yes ◯ no Uterine cancer

◯ yes ◯ no Colon cancer

◯ yes ◯ no Thyroid cancer

◯ yes ◯ no Diabetes

◯ yes ◯ no Kidney Disease

◯ yes ◯ no High Blood Pressure

◯ yes ◯ no Heart Disease

Other ______________________________

SOCIAL HISTORY

Occupation ______________________________ Marital Status ____________________

◯ yes ◯ no Smoking (list # packs per day and # years) ____________________

◯ yes ◯ no Alcohol (list how much and how often ____________________

◯ yes ◯ no Marijuana or other drugs: ____________________

HEALTH MAINTENANCE

Are you immune to rubella, chicken pox, and hepatitis B? ◯ yes ◯ no

Have you been exposed to people with tuberculosis? ◯ yes ◯ no

Do you work in a health care facility? ◯ yes ◯ no

If you are a candidate, are you interested in receiving the influenza vaccine (flu shot)? ◯ yes ◯ no

Have you had a tetanus diptheria booster within the last 10 years? ◯ yes ◯ no

When was the last time you had your cholesterol level checked? ◯ yes ◯ no

Please list any additional information that you feel is relevant: ______________________________