C O N F I D E N T I A L

Comprehensive New Patient Assessment – Adult Female – page 1

Name		Age	Date of Birth	Today's Date
Marital status?	☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Single ☐ Live with partner	Spouse/partner's name	I prefer to be addressed as (e.g., Rosie, Rose, Rose Marie, Mrs. Jones):	

CHIEF COMPLAINT

Briefly describe the main medical problem(s) you have **today**

FAMILY HISTORY List all immediate family members. List all known medical problems of each (including cause of death if appropriate). Be sure to include:

Diabetes	Heart disease	Heart attack	High blood pressure
Asthma	Colon polyps	Allergies	Bleeding tendencies
Anemia	Glaucoma	Emphysema	Lung disorder
Stroke	Hardening of the arteries	Deafness	Tuberculosis
Hepatitis	HIV/Aids	Genetic disorders	Birth defects
Cancer (list type)	Leukemia	Depression	Mental disorders
Epilepsy or seizures	Muscle disorders	Migraine headaches	Kidney disease

	Name			Living? Yes or No	Age now or at time of death	Medical problems (including cause of death if appropriate)
Mother						
Father						
Brothers and Sisters (✓full or half)		Full	Half			
Children						

Comprehensive New Patient Assessment – Adult Female – page 2

OCCUPATIONAL/EDUCATIONAL HISTORY

What type of work do you do?		Employer's name	
Have you worked extensively...		years		years
	at a coal mine?		with asbestos?	
	in a quarry?		with sand blasting?	
	in a farm silo?		with birds?	
	with toxic chemicals?		with radioactive materials?	

Have you served in the military?	Branch	Years of service	Warfare specialty	Do you also go to the VA clinic?

Education level achieved?

HEALTH RISK ASSESSMENT

Use of tobacco:	Cigarettes ☐	Age started _____	Packs/amount per day: _____	Are you ready to quit? ☐ Yes ☐ No	What methods have you used to quit?
☐ Never used it ☐ Used to but quit ☐ Still use it	Cigars ☐ Pipe ☐ Snuff/chew ☐	Age stopped _____			

What describes your use of alcoholic beverages? (may choose more than one)			
	☐ Never a drinker ☐ 1 – 5 drinks per year ☐ 1 – 2 drinks per month ☐ 1 – 2 drinks weekly ☐ 1 – 2 drinks daily	☐ 3 or more drinks daily ☐ Drink heavy on weekends only ☐ Heavy drinker all week ☐ One/both of my parents are alcoholics ☐ I need help	☐ Alcoholic ☐ Recovered alcoholic Sobriety date _____ I attend AA ☐ yes ☐ no

What describes your illegal drug use history? (may choose more than one)			
	☐ Never used drugs ☐ I use marijuana ☐ I use methamphetamine ☐ I use cocaine	☐ I use other drugs _____ ☐ I use intravenous drugs ☐ I have shared needles in the past ☐ I need help	☐ I have used IV drugs in the past ☐ I used to use drugs but quit Date of last drug use _____ I attend NA ☐ yes ☐ no

How much do you exercise per week?

Do you know your cholesterol levels?	☐ No	☐ Yes Total cholesterol _____ HDL_____ LDL_____ Triglicerides _____ Date _____
I wear my seat belt and shoulder harness?	☐ Always ☐ Never ☐ Sometimes ☐ Only on long drives	

IMMUNIZATION HISTORY

CHICKEN POX	I had ☐ Chicken pox ☐ Shingles	☐ I had the chicken pox vaccine _____ years ago.	
TETANUS	☐ My last tetanus shot was _____ years ago.	☐ I have never had a tetanus shot.	
FLU	☐ I get flu shots every year.	☐ I do not get flu shots because:	
PNEUMONIA	☐ I had a pneumonia shot _____ years ago.	☐ I have never had a pneumonia shot.	
HEPATITIS A	☐ I had hepatitis A in _____.	☐ I had hepatitis A shots.	☐ I have never had hepatitis A or the shots to prevent it.
HEPATITIS B	☐ I had hepatitis B in _____.	☐ I have had hepatitis B shots. Year completed _____ Has your titer been checked? ☐ yes ☐ no	☐ I have never had hepatitis B or the shots to prevent it.
MEASLES	☐ I was born before 1957 (no booster needed).	☐ I had a booster shot in _____. (Measles alone or MMR booster count)	☐ I was born after 1956 and I have never had a booster shot.
RUBELLA	☐ I had a booster shot in _____. (Rubella alone or MMR booster count.)	☐ I have delivered a baby. (Rubella immunity is checked and booster given, if needed, with all pregnancies.)	☐ I have never had a booster.

Comprehensive New Patient Assessment – Adult Female – page 3

CHRONIC DISEASES List all of your known chronic medical conditions or diseases

Disease or condition	Age at diagnosis	Current status	If you see a specialist, who do you see?

SURGERIES List all of your major surgeries

Type of surgery	Where done	Age or year	Surgeon's name

HOSPITALIZATIONS List all major hospitalizations other than for your chronic diseases/conditions or for surgeries listed above

Reason for hospitalization	Age or year	Treating physician/hospital

COLON CANCER SCREENING

Do you have a parent, sibling, or child with a history of colon cancer or colon polyps? ☐ Yes ☐ No	If yes, who?	Have you had your colon screened for cancer by sigmoidoscopy or colonoscopy? ☐ Yes ☐ No	If yes, when and by which doctor?

ALLERGIES List all drug, food, or other allergies you have

Drugs you are allergic to or make you sick	What happens if you take it?	Foods you are allergic to	Other things you are allergic to

Comprehensive New Patient Assessment – Adult Female – page 4

OBSTETRIC AND GYNECOLOGICAL HISTORY

Number of pregnancies	Number of deliveries	Number of miscarriages	Number of abortions	Number of tubal pregnancies

Date of first day of your last menstrual period	Are your periods regular?	How often do your periods occur?

Have you had a hysterectomy?	Have one or both ovaries been removed?	Have you had a tubal ligation?	Method of birth control, if any?	Do you desire to have more children?

When was your last mammogram?	Have you ever had an abnormal mammogram?	If yes, when and where was it done, and what was found?

When was your last pap smear?	Have you ever had an abnormal pap smear?	If yes, when was it done and what was found?

Menopause status:	If you are currently in menopause or if you have already pasted menopause, are you now or have you ever been on female hormone replacements?
☐ I have not reached menopause ☐ I am in menopause now ☐ I am postmenopausal	

List any current vaginal, menstrual or sexual problems

Do you want your annual breast and pelvic exams done here?	If not, which doctor will do them?

SEXUAL HISTORY My sexual status is:		If sexually active now:	If not in long-term monogamous situation:	Blood tests for HIV, Hepatitis B, and Hepatitis C:
☐ Heterosexual ☐ Bisexual ☐ Homosexual	☐ Virgin ☐ Sexually active in past but not for_____yrs ☐ Sexually active now	☐ long-term monogamous situation ☐ 2 - 5 partners in last year ☐ 6 - 10 partners in last year ☐ more than 10 partners in last year	☐ Always use condoms ☐ Sometimes use condoms ☐ Never use condoms	☐ I have been tested ☐ I want to be tested ☐ My partner has been tested ☐ I want my partner tested

CURRENT MEDICATIONS List all current medications, *including over the counter medicines and vitamins/supplements.*

Medications taken on a regular schedule:			Medications taken only *as needed:*			
Name of medication	Dose (mgs)	How taken (times per day, with food, at bedtime, etc.)	Medication	Dose (mgs)	Reason for use	How often actually used

Comprehensive New Patient Assessment – Adult Female – page 5

REVIEW OF SYSTEMS Check all of the following symptoms that you **now have:**

GENERAL/ CONSTITUTIONAL	☐ fever ☐ excessive fatigue	☐ unintended weight loss	☐ unintended weight gain	☐ severe night sweats ☐ other _____
SKIN	☐ itching ☐ hives ☐ corns ☐ growth you want removed	☐ burning ☐ fungus ☐ ingrown nail ☐ discolored/irregular mole	☐ mole you want removed ☐ warts ☐ skin tumor/growth ☐ mole that has changed	☐ acne ☐ chronic skin problem ☐ sores ☐ other _____
EAR/NOSE	☐ hearing loss ☐ pain ☐ sinus pain or pressure	☐ recurrent ear aches/infections ☐ drainage ☐ nose bleeds	☐ noises in the ear ☐ loss of smell ☐ recurrent sinus infections	☐ motion sickness ☐ chronic nasal drainage ☐ other _____
MOUTH/THROAT	☐ sore tongue ☐ recurrent sore throat ☐ cavities	☐ bleeding gums ☐ recurrent mouth ulcers ☐ tooth pain	☐ hoarseness ☐ thrush/white patches ☐ recurrent strept throat	☐ wear dentures ☐ peculiar taste ☐ other _____
EYES	☐ wear glasses/contacts ☐ colored halos around lights ☐ excessive tearing ☐ color blind	☐ blurry vision ☐ blind spots ☐ cataracts ☐ drainage	☐ double vision ☐ burning ☐ dryness	☐ glaucoma ☐ redness ☐ night blindness ☐ other _____
HEART/CIRCULATION	☐ chest pain ☐ heart attack in past ☐ legs/arms get cold ☐ spider veins ☐ short of breath if lying down ☐ rheumatic fever	☐ high blood pressure ☐ palpitations/heart pounding ☐ loss of hair on legs ☐ fingers turn blue, white or red ☐ need to take antibiotics before dental procedures	☐ swelling in feet or ankles ☐ irregular heart beat ☐ legs hurt after walking ☐ wake up short of breath at night	☐ heart murmur ☐ poor circulation ☐ varicose veins ☐ ulcers or sores on legs ☐ blood clots in past ☐ other _____
LUNGS	☐ chronic cough ☐ always short of breath ☐ asthma	☐ wheezing ☐ short of breath when climbing stairs	☐ cough up blood ☐ short of breath with mild exercise	☐ cough up sputum/phlegm ☐ use home oxygen ☐ other _____
DIGESTIVE	☐ loss of appetite ☐ bloating ☐ vomiting blood ☐ trouble swallowing	☐ nausea ☐ liver disease ☐ hemorrhoids/piles ☐ pancreatitis	☐ vomiting ☐ ulcers ☐ abdominal pain ☐ blood, mucous, puss in stools	☐ diarrhea ☐ gall bladder problems ☐ change in bowel habits ☐ constipation ☐ other _____
URINARY	☐ frequent nighttime urination ☐ urine leakage with cough, sneezing or laughing	☐ inability to hold urine ☐ leak urine ☐ bed wetting	☐ pain/burning with urination ☐ frequent urine/bladder/kidney infections	☐ difficulty starting urination ☐ other _____
BREAST	☐ lumps in breast	☐ painful breast	☐ drainage from nipple	☐ other _____
FEMALE ORGANS	☐ bleeding after intercourse ☐ pain with intercourse ☐ sexually transmitted disease	☐ flooding ☐ partner has/may have sexually transmitted disease	☐ irregular periods ☐ vaginal discharge ☐ hot flashes	☐ no periods ☐ yeast infections ☐ other _____
SEXUAL	☐ lack of interest/low sex drive	☐ unable to reach orgasm	☐ partner lack of interest/drive	☐ partner impotent ☐ other _____
NERVOUS	☐ seizures/convulsions ☐ temporary blindness ☐ paralysis	☐ numbness ☐ weakness of extremity ☐ polio	☐ fainting spells ☐ dizzy spells ☐ meningitis	☐ severe headaches ☐ stroke ☐ other _____
MUSCULOSKELETAL	☐ painful joints ☐ arthritis	☐ muscle pain ☐ carpal tunnel syndrome	☐ swollen joints ☐ back pain	☐ gout ☐ other _____
GLANDS	☐ very sensitive to temperature changes ☐ excessive fluid intake	☐ hair loss ☐ thinning/coarsening of hair	☐ thyroid disorder ☐ frequent urination	☐ diabetes ☐ constantly thirsty ☐ other _____
MENTAL	☐ depressed ☐ suicidal thoughts ☐ unable to concentrate	☐ excessive worry ☐ hear voices ☐ cry too much	☐ excessive anger ☐ memory problems ☐ unhappy	☐ sleep problems ☐ sleep too much ☐ other _____

Comprehensive New Patient Assessment – Adult Female – page 6

REVIEW OF SYSTEMS (continued) Check all of the following symptoms that you now have:

BLOOD/LYMPH	☐ anemia	☐ swollen lymph nodes	☐ bleed easily	☐ easy bruising ☐ other _____
ALLERGY/IMMUNITY	☐ hay fever	☐ allergies	☐ immune deficiency	☐ HIV/AIDS ☐ other _____

SOCIAL HISTORY

Who was your previous family physician?	Who else lives in your household?	If the patient was unable to complete this form, who filled it out?

DIET HISTORY

I am on the following special diet:

ADVANCED DIRECTIVES

Do you have a living will? ☐ Yes ☐ No	Have you legally appointed a **healthcare representative** to make medical decisions in the event you are incapacitated and unable to make decisions for yourself? ☐ Yes ☐ No	If yes, who is your healthcare representative?	Do you want to be an organ donor? ☐ Yes ☐ No

REVIEWED BY PHYSICIAN

Signature of doctor	Date	Signature of doctor	Date	Signature of doctor	Date