New Patient Information

Today's Date: _______________

Patient Information

Patient's Name:____

Date of Birth:____________________________ Age:_________________________

Race:_________________________ Primary Language:______________________

Referral

Name of Referring Physician: ____

Address/ Phone: ____

Name of Primary Care Physician:____

Address/ Phone: ____

Chief Complaint (current problem)

____

____

____

Medical History (illnesses)

____

____

____

____

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Past Surgeries (include date of surgery and hospital, if possible)

____

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____

Previous Hospitalizations

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____

Current Medications (include vitamins and herbal medications)

Name of medication	Dose	Frequency

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Medication Allergies

Name of medication	Reaction

Past Obstetrical and Gynecologic History

Age of onset of menstrual cycle (approximate):_________________________________

Duration of menstrual cycle (how many days to you bleed?):______________________

Age of menopause (if applicable):____

Any history of bleeding in between cycles? ____________________________________

Any history of bleeding after menopause?_____________________________________

Any history of a dilation and curettage (D&C)? _________________________________

Number of living children: ____

Number of pregnancies: ____

Number of miscarriages or terminations:_______________________________________

Date of last menstrual cycle:____

Have you ever received a blood transfusions?__________________________________

Have you ever taken any hormones (include birth control pills)?___________________

Have you ever taken any hormone replacement therapy?________________________

Screening Tests & Immunizations

Test or recent immunization	Approximate date	Result or test
Mammogram		
Colonoscopy		

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Family History

Any history of Ashkenazi Jewish ancestry?

Have you or any of your relatives been tested for a hereditary cancer syndrome (i.e. BRCA, Lynch or Cowden syndrome)?

Any history of male breast cancer in your family?

	Medical problems	Cancer history and age of cancer diagnosis	If deceased, age and cause of death
Example	*Diabetes*	*Colon cancer, age 50*	*Died at age 60, colon cancer*
Father			
Mother			
Sibling			
Sibling			
Child			
Child			
Child			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			
Aunt			
Uncle			
Other			
Other			
Other			

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Social History

Marital status (married, single, divorced, widow):

Most recent or current job:

Substance	Never	Current use & how much *Example: smoke 1 pack per day, drink 1 beer per day*	Former use & how much *Example: smoke 1 pack per day, drink 1 beer per day*
Alcohol use			
Tobacco			
Drug use			

REVIEW of SYSTEMS

Patient Name: ____Date:___________________________

Please write down today's main complaint (reason for your appointment). Please specify any new symptoms since your last visit.____

PLEASE CHECK ONLY THOSE THAT APPLY

GENERAL
_____Weight loss? How much? _____
_____Decrease in energy
_____Decrease in appetite
_____Night sweats
_____Difficulty sleeping
_____Fever, if so how high? _______

HEAD, EYES, EARS, NOSE, THROAT
_____Sinus infection/pain
_____Ear pain
_____Ringing in ears
_____Change in hearing
_____Change in vision
_____Throat pain
_____Stiff neck
_____Lumps in neck

CARDIAC
_____Chest pain
_____Irregular heartbeat
_____Shortness of breath on exertion
_____Night time shortness of breath

RESPIRATORY
_____Cough, or change in cough
_____Mucous produced with cough
_____Shortness of breath when lying down
_____Wheezing

PSYCHIATRIC
_____Change in behavior with family
_____Change in ability to think
_____Losing track of where one is, time it is, or who one is

HEMATOLOGIC
_____Nosebleeds, easy bruising or bleeding at other sites

EXTREMITIES
_____Redness of a limb
_____Swelling of a limb or discoloration of a limb
_____Pain in legs when walking

GENITOURINARY
_____Burning with urination
_____Blood in urine
_____Increase in need to urinate (day or night)
_____Incontinence of urine
_____Discharge from vagina
_____Pain with sexual intercourse

MUSCULOSKELETAL
_____Arthritis
_____Chronic back pain
_____Bone pain
_____Recent trauma or fractures

SKIN
_____Infections
_____Ulcer
_____Rashes

NEUROLOGICAL
_____Headaches
_____Change in ability to feel things (numbness)
_____Decrease in muscle strength
_____Trouble walking
_____Fainting
_____Seizures

GASTROINTESTINAL
_____Pain or difficulty swallowing food
_____Indigestion/ heartburn
_____Nausea
_____Vomiting
_____Diarrhea
_____Abdominal pain
_____Black stools
_____Blood from the rectum
_____Constipation
_____Incontinence of stool

Please list any drug allergies: ____

Are you taking any new medications since your last office visit? ____

Have you received any new immunizations (vaccines) since your last office visit? __________________________

Do you have an Advance Directive? ____

Patient Signature: ____

Personal and Emergency Contact Information

Personal Information

Name: ____________________

Home Address: ____________________

____
City State Zip code

Date of Birth: ____________________

□ Married □ Single □ Widowed □ Divorced

Home Phone: ____________________ Cell Phone: ____________________

E-mail (Home): ____________________

Employer: ____________________ Occupation: ____________________

Work Address: ____________________

____
City State Zip code

Work Phone: ____________________ E-mail (Work): ____________________

Insurance Information

Primary Insurance: ____________________

Policy Holder Name: ____________________

Policy Holder Date of Birth: ____________________

Insurance ID #: ____________________

Insurance Group #: ____________________

Relationship to Patient: ____________________

Secondary Insurance (if any): ____________________

Policy Holder Name: ____________________

Policy Holder Date of Birth: ____________________

Insurance ID #: ____________________

Insurance Group #: ____________________

Relationship to Patient: ____________________

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Personal and Emergency Contact Information

Pharmacy Information:

Pharmacy Name____________________

Pharmacy Adress:____________________

Pharmacy Phone Number:____________________

Primary person to be notified in case of an emergency:

Name: ____________________

Relationship: Relative __________ Friend __________ Other __________

Home Address: ____________________
Street Address City State Zip code

Home Phone: __________ Work Phone: __________ Cell Phone: __________

E-mail Address: ____________________

Secondary person to be notified in case of an emergency:

Name: ____________________

Relationship: Relative __________ Friend __________ Other __________

Home Address: ____________________
Street Address City State Zip code

Home Phone: __________ Work Phone: __________ Cell Phone: __________

E-mail Address: ____________________

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by North Houston Gynecologic Oncology Surgeons, PLLC and emergency personnel. Please ensure that the form has the most updated and accurate information.

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this form may be notified in an emergency as needed.

Signature: ____________________Date:____________________