New Patient Medical History

Date:

Patient Name:

DOB:

Welcome to Genesee Valley OBGYN! In order to maximize your visit, we would like you to fill out your past medical history on the PATIENT PORTAL. However, if you are unable to complete that form on the PATIENT PORTAL then please complete and submit the following form.

1. Do you have any COVID concerns?

Yes

No

****Up to the day of your appointment if your answer changes to yes, please contact our office prior to the appointment. ***

Reason for your visit today:

Due to time constraints and insurance coverage, "problem visits" cannot be done at the time of your routine well visit. A separate visit will likely be required.

OB/GYN History:

Total number of pregnancies:

Dates and outcomes of each pregnancy: (Vaginal, C-section, miscarriage, abortion, full term, preterm, gender and baby's weight)

What was your age at your first menstrual period?

If you are menopausal, at what age did you have your last period?

What are you using for contraception or to prevent pregnancy (if applicable)?

When was your last Mammogram (if applicable)?

When was your last Colonoscopy (if applicable)?

When was you last Pap Smear (if applicable)?

Have you ever had an abnormal pap smear and if so, what was the approximate date and level of abnormality?

When was your last Bone Density Test (if applicable)?

When was your last visit with your Primary Care Physician?

Have you had the Gardasil (HPV) Vaccine?

Have you had the Covid Vaccine?

Medical History:

Please list all current and past medical diagnosis that you have had. Please list none if applicable.

Surgical History:

Please list all prior surgeries you have had with the dated if known. Having these dates can be helpful.

Please list none if applicable.

Have you had any complications with anesthesia or surgery, if so, what?

Family History:

Please list all medical diagnosis for each family member. Please list none if applicable.

Father:

Mother:

Siblings (please specify whom):

Grandparents (please specify whom):

Children (please specify whom):

Please list any family history of cancers, especially breast, ovarian, colon or uterine. Please state the relationship of that family member to you.

Social History: Health care guidelines recommend that we ask these questions to optimize your total health care. We do understand that these questions can be uncomfortable for some to answer, and we want you to know you privacy is assured.

What was your highest education level achieved?

What is your marital status?

Who do you live with?

What is your Occupation?

What is your work status?

☐ Full-time

☐ Part-time

☐ Unemployed

☐ Retired

☐ Disabled

Do you have any history of abuse?

☐ Sexual

☐ Physical

☐ Verbal

☐ Mental

☐ None

What is your smoking history?

☐ Never smoked

☐ Former smoker

☐ Current smoker

Do you drink alcohol?

☐ Never

☐ Occasional

☐ Dependent

Do you use drugs? Never, occasional, or dependent

☐ Never

☐ Occasional

☐ Dependent

If so which ones? (For example, THC, Cocaine, Narcotics)

Do you exercise?

☐ Never

☐Sporadically

☐ Regularly

Are you sexually active?

☐ Never

☐ Yes

☐ Not currently

What was your age the first time you had sexual intercourse (if applicable)?

What is the approximate total number of sexual partners you have had (if applicable)?

Do you have any history of sexually transmitted diseases? (For example, herpes, HIV, gonorrhea, chlamydia,etc.) if so, which ones?

What is your sexual preference?

☐ Men

☐ Women

☐ Both

☐ Other

What is your preferred pronoun?

☐ She

☐ He

☐ They/Them

☐ Ze

☐ Other