Karen H. Clark, M.D.

NEW PATIENT MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ AGE: _____

Reason for your visit today: _____

Primary care physician: _____

PAST MEDICAL HISTORY

Surgeries: _____

Illness(es): _____

Please check any of the following illnesses that you have had:

- ☐ Blood clots in lungs or legs
- ☐ Breast disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Gallbladder disease
- ☐ Migraine / severe headaches
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney infections / stones
- ☐ Mitral valve prolapse
- ☐ Thyroid problems
- ☐ Transfusions (year _____)
- ☐ Prolonged bleeding with trauma or surgery

Injuries: _____

Immunizations:

☐ Hepatitis B ☐ Hepatitis A ☐ Chicken pox ☐ HPV Last tetanus shot: _____

PAST GYNECOLOGIC HISTORY

Age when period started: _____ Last menstrual period: _____

Number of days between the ***first*** day of your period to the ***first*** day of your next period: _____

Any recent changes in periods? _____

Do you have bleeding between periods? ☐ No ☐ Yes

Number of pads or tampons used on heaviest day of flow: _____

Menstrual cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you ever had any of the following?

- ☐ Ovarian cysts
- ☐ Fibroids
- ☐ PMS/PMDD
- ☐ Endometriosis
- ☐ DES exposure
- ☐ Genital herpes
- ☐ Genital warts
- ☐ Chlamydia
- ☐ Exposure to HIV
- ☐ Syphilis
- ☐ Trichomoniasis
- ☐ Gonorrhea

Last Pap smear: _____

Have you ever been treated for an abnormal Pap smear? ☐ Yes ☐ No

Explain: _____

Last mammogram: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

Explain: _____

Have you ever had a bone density scan performed? ☐ Yes ☐ No ☐ Date _____

Have you ever had colon cancer screening (colonoscopy or sigmoidoscopy)?

☐ Yes ☐ No ☐ Date _____

Are you interested in screening for sexually transmitted infections? ☐ Yes ☐ No

☐ Chlamydia/ gonorrhea ☐ HIV ☐ Syphilis
☐ Hepatitis B ☐ Hepatitis C ☐ Trichomoniasis

PREGNANCY HISTORY

Total number of pregnancies: _____ Number of full-term births: _____
Number of preterm births: _____ Number of miscarriages, ectopics, or abortions: _____
Number of living children: _____ Number of adopted children: _____

FAMILY HISTORY

Please check any of the following illnesses that run in your family:

☐ Breast cancer ☐ Heart disease ☐ Diabetes
☐ Ovarian cancer ☐ Stroke ☐ Thyroid problems / goiter
☐ Colon cancer ☐ High blood pressure ☐ Osteoporosis

SOCIAL HISTORY

Tobacco use: ☐ No ☐ Former smoker
☐ Yes Packs per day _____

Recreational/ Street Drug use:
☐ Yes ☐ No ☐ Previous

Alcohol use (including wine and beer): ☐ None
☐ Yes Drinks per week _____

Seatbelt use: ☐ Yes ☐ No ☐ Sometimes
Are you currently sexually active? ☐ Yes ☐ No
Do you need contraception? ☐ Yes ☐ No
What do you currently use for contraception? _____

Marital status: ☐ Single ☐ Married ☐ Domestic partnership ☐ Separated since _____
☐ Divorced since _____ ☐ Widowed since _____
Occupation: _____
Do you get regular exercise? ☐ No ☐ Yes Describe: _____
Have you ever been abused, threatened, or hurt by anyone? ☐ No ☐ Yes

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ALLERGIES TO MEDICATIONS

Please list any medication allergies.

1. _____ 3. _____
2. _____ 4. _____

MEDICATIONS / VITAMINS / HERBS

Please list any medications, vitamins, or herbal supplements that you are currently using, including dose.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Others: _____

Do you currently have any of the following symptoms? Please check all that apply.

(GENERAL)	☐Change in appetite ☐Fever	☐Significant weight change ☐Sweats	☐Chills
(HEENT)	☐Use of glasses/contacts ☐Frequent nosebleeds	☐Hoarseness unrelated to a cold ☐Sinus problems	☐Visual problems ☐Ringing in ears
(RESP)	☐Chronic cough	☐Wheezing	☐Coughing up blood
(CV)	☐Chest pain	☐Shortness of breath	☐Palpitations
(GI)	☐Abdominal pain ☐Frequent diarrhea	☐Nausea/vomiting ☐Blood in bowel movements	☐Indigestion ☐Constipation
(BREAST)	☐Breast pain	☐Nipple discharge	☐Lumps
(GU)	☐Pain with urination ☐Involuntary loss of urine	☐Blood in urine	☐Frequency
(CNS)	☐Dizziness	☐Loss of consciousness	☐Frequent headaches
(SKIN)	☐Rashes	☐Non-healing sores	☐Changes in moles
(PSYCH)	☐Depression ☐Memory problems	☐Anxiety	☐Insomnia
(ENDO)	☐Temperature intolerance	☐Abnormal thirst	
(IMMUNO)	☐Allergies to pollens ☐Foods	☐Grasses	☐Pets