Riverview MEDICAL GROUP

NEW PATIENT CLINICAL INFORMATION:

Date: _____

Name: _____ DOB: _____ Allergies: _____

Please describe the reason for your visit today: _____

MENSTRUAL HISTORY

Age at onset: _____ LMP: _____
Do you have a period regularly every month? Yes No
Do you have bleeding between your periods? Yes No
Length of Cycle (from start to start): _____Days
Duration of bleeding: _____Days
Flow: Light Moderate Heavy
Pain/Cramps: Mild Moderate Severe

GYNECOLOGIC HISTORY

Method of Birth Control: _____
Prior Infections: ☐ Chlamydia ☐ Gonorrhea
☐ PID ☐ Herpes ☐ Other _____
Have you had:
☐ Abnormal Periods ☐ Pelvic Pain
☐ Ovarian Cysts ☐ Endometriosis
☐ Incontinence ☐ Leakage of Urine
☐ Pain during intercourse ☐ Abnormal Pap Smear

PERSONAL HISTORY

Please check YES or NO if you currently have or have ever had any of the following. Please include age at diagnosis.

	YES	NO	AGE
Heart Disease			
High Blood Pressure			
Heart Murmur			
Stroke			
Blood Clots/Disorders			
Anemia			
Depression/Anxiety			
Lung Disorders			
Thyroid			
Diabetes			
Osteoarthritis			
Other Unlisted Disorder			
Cancers:			
Breast Cancer			
Ovarian Cancer			
Colon Cancer			
Uterine Cancer			
Other Cancers			
Family:	Are you of Ashkenazi Jewish descent? YES NO		

FAMILY HISTORY

Please include the relative (mom, dad, siblings, grandparents, aunts, uncles or cousins) who currently have or have ever had any of the following. Please include age at diagnosis.

Mother's Side	AGE	Father's Side	AGE

SOCIAL HISTORY:

Cigarettes: ☐ Never ☐ Currently Age Started _____ Quit Date: _____

Alcohol: ☐ Never ☐ Occasionally ☐ Daily Number of drinks per week _____ per day_____

Street Drugs: ☐ Never ☐ Marijuana ☐ Cocaine ☐ IV Drugs Other _____

Abuse: ☐ Never ☐ Currently ☐ Past

MEDICATIONS: Please list any medications that you are taking.

PREGNANCY HISTORY: Please include miscarriages.

Year	Sex	Infant Weight	Type of Delivery	Hours of Labor	Complications	Gestational Age at Delivery: #of weeks

SURGICAL HISTORY: Please list any surgeries that you have had and the date you had them.

HEALTH MAINTENANCE: Please list the date of your most recent exam.

Mammogram _____ Bone Density_____ Pap Smear_____ Colonoscopy_____

Vaccines_____