The Einhaus Group for Women's Health
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Patient Name: ______________________ **Date of birth:** ____________ **Age:** ______

NEW PATIENT HISTORY FORM

Abnormal Pap Smears

Date	Diagnosis	Physician seen

How many times have you been pregnant? ______
How many miscarriages or abortions have you had? ______
How many preterm deliveries have you had? ______
How many living children do you have? ______
Have you ever had a history of domestic violence? Yes No
How old were you when you first started your menstrual cycle? ______
When was your last menstrual period? ______
How many days from the first day of your cycle
to the next first day of your cycle? ______
How many days do your periods last? ______
Are you menopausal? Yes No Unsure

What do you use for birth control? ______________________

Current Medications

Name of Medication	Date Started	Dosage	Physician who prescribes this medication

(Please use the back of this paper if your medications exceed this space)

Social History

Do you drink alcohol? Yes No How often?______________
Do you drink caffeine? Yes No How often?______________
Do you exercise? Yes No How often?______________
Do you do self breast exams? Yes No How often?______________
Do you have a family physician? Yes No Name:______________
Are you married? Yes No
Do you believe you have significant stress? Yes No
Do you smoke? Yes No How many packs per day?______________
Have you ever smoked? Yes No

Family History

Pertinent negatives: Please circle yes or no to the following family history questions:

Cancer **Yes No**, Osteoporosis **Yes No**, Cardiovascular disease **Yes No**, Diabetes **Yes No**
Hypertension **Yes No**, Elevated cholesterol **Yes No**, Stroke **Yes No**, Thyroid disease **Yes No**

If you circled yes to any of the above illnesses, please explain below along with all other significant family history

(example)

Disease	Relation to you	Maternal(mother) Paternal (father)	Age diagnosed	Living or Deceased
Breast Cancer	*Aunt*	*paternal*	*52*	*Living*

Serious Illnesses

(example)

Illness	Date diagnosed	Medication for illness	ManagingPhysician Name
Migraine headaches	*5/2006*	*Imitrex*	*Dr. Einhaus*

Do you have any drug allergies? Yes No

(example)

Medication allergy	Reaction	Medication allergy	Reaction
Sulfa	*Hives*	*Penicillin*	*vomiting*

Surgery

(example)

Surgery performed	Date	Surgeon Name
Hysterectomy	*1998*	*Dr. Einhaus*