Lifeline Medical Associates
Transforming Women's Healthcare

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New Patient History

Name:_____ DOB:_____ Date:_____

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize that this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you.

What is your main reason for coming to the doctor today?_____

Menstrual History:

What are you using for birth control:_____
First Day of Last Period:___/___/____ **Periods occur:** ___regularly ___irregularly ___absent **First Period at Age:**_____
Period lasts for: _____ days **Flow:** ___Heavy ___Light ___Normal ___Spotting **Frequency:** ___ <28 days
___>28days ___every 28 days **Cramps:** ___yes ___no **Breast symptoms:** ___discharge ___lumps ___pain ___self exam

Postmenopausal:
At Age:_____ Hormone replacement therapy:_____

Associates Symptoms: ___hot flashes ___insomnia ___night sweats ___vaginal dryness ___Abnormal bleeding ___ Anxiety ___Decreased libido ___Depression ___Difficulty falling asleep ___sexual dysfunction ___urinary incontinence ___urinary urgency

Diagnostic Testing:
Mammogram: Date___/___/_____ Results_____
Bone density: Date___/___/_____ Results_____
Cholesterol: Date___/___/_____ Results_____
Colonoscopy: Date___/___/_____ Results_____

Nutrition:
General Diet: ___healthy ___gluten-free ___low fat ___vegan ___vegetarian ___other:_____

Multivitamin: ___daily ___occasionally Calcium: ___dietary sources ___supplement ___mg/day

Vitamin D: ___adequate sunlight exposure ___supplement Folic acid: ___daily ___occasionally

Social History:
Tobacco Use:
Type of Tobacco:_____ Daily Use: ___yes ___no Usage per day: ___cigarettes ___packs
Age Started:_____ Age Stopped:_____ Efforts to Quit:_____

Alcohol Use:
Type Consumed:_____ Frequency: __Daily __Weekly __Occasionally __Rarely __Socially Amount:_____
Caffeine Intake: ___yes ___no Type:_____ Amount:_____

Exercise/Activity:
Level: ___Moderate ___Sedentary ___Vigorous
Frequency: ___ 2-3 times/week ___ 3-4 times/week ___Daily ___Occasionally ___Never

Medical History:

__Abnormal PAP __Anemia __Asthma __Autoimmune disease __Bartholin's gland cyst __Breast mass __Bruising/bleeding disorder __Cancer Which Type?_____ __Cardiovascular disease __Clotting disorder __Depression __Diabetes __Elevated lipids __Endometriosis __Fibroid uterus __Gallbladder disease __Genital herpes simplex __Genital herpes, exposure __Heart murmur __Hepatitis/liver disease __Hypertention __Hyperthyroidism __Hypothyroidism __Incompetent cervix __Infertility __Mental disorder __Obesity __Ovarian cyst __Pelvic inflammatory disease __Pulmonart embolism __Recurrent miscarriages __Recurrent vaginal infections __Recurrent urinary tract infections __Renal disease __Seizure disorder __Sexually transmitted disease __Stroke __Tuberculosis __Varicose veins

Any others not listed above:_____

Surgical History:

__Angioplast __Appendectomy __Arthroscopy __Back surgery __Bilateral oophorectomy __Bilateral tubal ligation __Blood transfusion __Breast augmentation __Breast reduction __CABG __Cardiac pacemaker __Chemotherapy __Cholecystectomy __D&C __Gastric bypass __Hernia repair __Hip replacement __Hysterectomy __Knee replacement __Mastectomy __Myomectomy __Pelvic sling __Radiation therapy procedure __Tonsillectomy __Thyroidectomy __Other

Please specify if necessary:

_____

_____

Pregnancy History:

# of pregnancies:_____ # of therapeutic abortions:_____ # of miscarriages:_____ # of children born alive:_____

Vaginal Deliveries:_____ # Cesarean Sections:_____ # Pre-Term:_____ # Full-Term:_____

If you had any miscarriages, how far along were you?

Date:__/__/__ Duration of Pregnancy: _____

Date:__/__/__ Duration of Pregnancy: _____

Date:__/__/__ Duration of Pregnancy: _____

Have you had any blood transfusions?_____ Have you ever taken a fertility drug of any kind? Which?_____

Date	Hours Labor	Birth Weight	Sex	Delivery Type	Anesthesia	Pre-term/ Full-term	Comment/ Complications	Location

Immunizations:

___HPV ___Measles, Mumps, Rubella (MMR) ___DPT ___Smallpox ___Hepatitis ___Polio ___Tetanus

Adult immunizations:

___Flu ___Pneumonia ___Hepatitis ___TB Skin Test ___HPV (Gardasil)

Medications:

Medication	Strength	Directions	Reason for Medication

Allergies:

Allergy	Reaction

Family history: Please check all that apply.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Alive & Well												
Deceased (please specify age)												
High Blood Pressure												
Diabetes												
Breast Cancer												
Uterine Cancer												
Colon Cancer												
Ovarian Cancer												
Other Cancer (please specify)												
Thyroid Disease												
Kidney Disease												
Heart Disease												
Anemia												
Birth Defects												

Other Relevant Family Information:_____

_____

Review of Systems: Please check any symptoms you are **currently** experiencing

Constitutional	**Respiritory**	**Cardiovascular**
Chills Fatigue Fever Malaise Night Sweats Weight gain Weight loss	Chronic cough Cough Known TB exposure Shortness of breath wheezing	Chest pain Bruising Palpitations Poor circulations Arrhythmia
Reproductive	**Gastrointestinal**	**Genitourinary**
Abnormal pap Dysmenorrhea Hot flashes Irregular menses Vaginal discharge Pelvic pain Vaginal dryness Bleeding between periods	Abdominal pain Blood in stools Constipation Diarrhea Heartburn Nausea Vomiting Loss of appetite	Dysuria Urinary frequency Urinary retention Urinary incontinence Recurrent UTI Blood in urine Incomplete urination
Neurological	**Musculoskeletal**	**Psychiatric**
Dizziness Extremity weakness Extremity numbness Gain disturbance Headache Memory loss Seizures Sciatica	Back pain Joint pain Muscle weakness Neck pain Joint swelling	Anxiety Depression Insomnia Difficulty sleeping Stress Behavioral change Impaired judgment
Integumentary	**HEENT**	**Immunologic**
Breast discharge Breast lump Brittle hair or nails Hair loss Unwanted facial hair Rash Mole changes Eczema	Ear drainage Ear pain Eye discharge Eye pain Hearing loss Nasal drainage Sinus pressure Sore throat Visual changes	Contact allergy Seasonal allergies Food allergies Environmental allergies Latex allergy