R-P-W Obstetrics & Gynecology S.C.

NEW PATIENT INFORMATION

Date:_____

Patient Name:_____

Chief Complaint:_____

_____

Duration of Problem:_____

Signs & Symptoms:_____

_____

What medications/dosages are you **currently** taking?

_____ _____

_____ _____

_____ _____

Have you had any previous hospitalizations, including any past surgeries?
If so, where and when were you hospitalized?

_____

_____

_____

_____

PATIENT MEDICAL HISTORY (please circle correct answer)

Diabetes……..	no	yes	
Hypertension……	no	yes	
Cancer……	no	yes	
If yes, what type?_____			
Stroke……..	no	yes	
Heart Disease……..	no	yes	
Arthritis……	no	yes	
Gynecological Problems……..	no	yes	
If yes, what type?_____			
Pregnancy……..	no	yes	How many?_____
Miscarriages……..	no	yes	How many?_____

PATIENT SOCIAL HISTORY – please complete

Marital status:	Single___	Married___	Separated___	Divorced___	Widow___
Alcohol use:	Never___	Rarely ___	Moderate___	Daily___	
Tobacco use:	Never___	Previous/quit_____		Current packs per day _____	
Drug use:	Never___	Type/frequency _____			

FAMILY MEDICAL HISTORY – please complete

	Age	Diseases	Deceased/cause & age
Spouse			
Children			
Father			
Mother			
Siblings			

_____ _____

PHYSICIAN'S SIGNATURE DATE