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