Stanford HEALTH CARE

Label

New Patient

Today's Date: _____

Preferred Name: _____

Age:_____ First day of last period: _____

Reason for visit: _____

_____

These questions cover important gynecological issues for everyone. We strongly encourage everyone to have a Primary Care Physician to cover other health issues.

What is your gender identity: _____ Pronouns:

ALLERGIES

Do you have any food allergy? _____

Please list any medication or drug allergies you have below: ☐ None

Drug Name	Reaction

Drug Name	Reaction

MEDICATIONS

Please list any prescribed medications you are taking: ☐ None

Medication Name	Dose/Strength	How do you take it?	Refill
			☐
			☐
			☐
			☐
			☐

Please list any non-prescribed or over the counter medications you are taking: ☐ None

Over the past 2 weeks, how often have you been bothered by any of the following: (*Please x response)*

	0- Not at all	1- Several days	2- More than ½ the days	3- Nearly every day
1. little interest or pleasure in doing things	☐	☐	☐	☐
2. feeling down, depressed, or hopeless	☐	☐	☐	☐

Clinic Use Only: Height _____ Weight _____ BP _____

Orders: ❑ Pap smear ❑ Mammogram ❑ DXA ❑ STI ❑ CT/GC ❑ Labs ❑ Immunization_____ ❑ Referral

Label

CONTRACEPTION (***Skip if no longer having periods/menopause)***

Current birth control method? _____
Do you want to change?
Thinking of conceiving in the next year?

SEXUAL HEALTH

Are you sexually active? Partners:
More than one partner this year? Do you have problems with intercourse?

MENSTRUAL HISTORY

Still having periods, please answer the following: First day of last menstrual period:_____
What age did your periods begin: ____ Length of period (days): ____ Number days between periods _____
Are your periods? ___ Painful (cramps) ___ Heavy / Cause you to miss work or activities?

No longer having periods/menopause, please answer the following:
At what age did you stop having periods? _____
Have you had a hysterectomy? what year? _____
Were your ovaries removed? Was your cervix removed?
Are you taking or have taken hormone therapy?

GYNECOLOGICAL HISTORY- Check all that apply for past or present conditions ☐ **None**

☐ Abnormal pap smear/HPV	☐ Genital warts	☐ Infertility
☐ Abnormal pap smear treatment	☐ Gonorrhea	☐ Pelvic / Tubal Infection
☐ Abnormal Uterine Bleeding	☐ Gynecological Cancer	☐ Polycystic Ovary Syndrome
☐ Chlamydia	☐ Herpes	☐ Syphilis
☐ DES Exposure	☐ Hepatitis B	☐ Trichomonas
☐ Endometriosis	☐ Hepatitis C	☐ Uterine fibroids
☐ Ovarian Cysts	☐ HIV	

MEDICAL HISTORY

MEDICAL CONDITIONS YOU HAVE OR HAVE HAD: ☐ None

Do you have an abnormality of your uterus? what kind?_____

SURGERIES (*PLEASE INCLUDE MONTH/YEAR*): ☐ None

SOCIAL HISTORY

What is your occupation? _____

What is your relationship/marital status? _____

Label

Do you currently use tobacco products?

If yes, are you ready to quit?

How many years have you smoked?_____

How many packs per day? _____

How often do you use:

Tobacco?	Type:_____	☐ Former year quit: _____
Smokeless Tobacco?		☐ Former year quit: _____
Alcohol?		☐ Former year quit: _____
Marijuana?	Type:_____	☐ Former year quit: _____
Recreational Drugs?	Type:_____	☐ Former year quit: _____
E-Cigarette/vape?		☐ Former year quit: _____

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?

Do you feel safe in your current relationship?

Is there a partner from a previous relationship who is making you feel unsafe now?

FAMILY HISTORY Are you adopted?

Please write list immediate family members (1st degree) who have:

Breast Cancer _____ Colon Cancer _____

Ovarian Cancer _____ Other Cancer _____

PLEASE PROVIDE DETAIL AS APPLICABLE

Relationship	Name	Status/Age	List any/all Medical Conditions
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			
Other			

Label

PREGNANCY HISTORY

How many times have you been pregnant? _____

How many children are living? _____ Twins? _____

How many deliveries were Vaginal _____ Cesarean Section _____ VBAC _____

How many pregnancies resulted in a Miscarriage _____ Abortion ____ Ectopic _____

If you had a miscarriage or abortion, did you take pills or have a D&C procedure? , which _____

Month/Year	Birth Weight	Gender	Weeks Pregnant	Type of Birth	Complications

PREVENTATIVE HEALTH HISTORY

Have you had a blood test for Hepatitis C?

12 years of age and older Have you had the Human Papilloma Virus Immunization (Gardasil)?

21 years of age and older: Date of your last Pap Smear_____ Was it normal?
Have you had an abnormal pap? Year? _____, Colposcopy for abnormal pap smear?
Treatment for abnormal pap smear? , Treatment Performed: ☐Cryotherapy ☐LEEP ☐Cone Biopsy

40 years of age and older: Date of your last Mammogram _____ Location _____ ☐N/A
Have you ever had an abnormal mammogram? , what was done? ☐Repeat imaging ☐Biopsy
Do you perform monthly breast self- examinations

50 years of age or older Date of your last Colonoscopy _____ ☐ N/A

65 years of age or older Date of your last Dexa/bone scan _____ ☐ N/A

Have you had other health screenings this year? *Please list*:

_____

_____

Label

Immunizations	*Please write date received:*	
	Influenza (flu): _____	*Recommended yearly*
	Tdap: _____	*Recommended every 10 years*
	Pneumococcal: _____	*Recommended after age 60 or younger with risk factors*
	Shingrix: _____	*Recommended after age 50*
	HPV (Gardasil): _____	☐Series completed (2 or 3 dose)
	Covid-19: _____	Brand: ☐Pfizer ☐Moderna ☐J&J ☐Other
	Covid-19 Booster:_____	Brand: ☐Pfizer ☐Moderna ☐J&J ☐Other

Please list names and specialty of other current health care providers you have:

Name	Specialty

If completing form by computer, please save your responses and send us a MyHealth message and attach the file (PDF only). Otherwise please return completed form to the receptionist. Thank you.