Women's Care Specialists
Washington University Clinical Associates

NEW PATIENT HEALTH HISTORY
(Please Fill Out Completely)

PATIENT NAME:_____ DOB:___/___/_____ TODAY'S DATE:_____

Reason for your visit	**Primary Care Provider**
_____	Name:_____
_____	Phone:_____
_____	Pharmacy:_____

GYNECOLOGIC HISTORY
Date of last menstrual period:_____ Age of first period:____ Age of menopause:____

Menstrual frequency (ex: Every 28-30 days) :_____ How many days bleeding lasts:____

Any abnormal bleeding? Y N
Are you sexually active? Y N
Pain with periods? Y N
Pain with intercourse? Y N

History of sexual/physical abuse? Y N
Would you like a chaperone present during your exam? Y N
History of sexually transmitted infections (ex: Chlamydia)? Y N
Are you using birth control? Y N
If yes, what type of birth control?_____
Sterilization (circle one): Tubal / Vasectomy / None

Date of last Pap smear:_____ Results:_____ Any abnormal Paps:_____
Date of last mammogram:_____ Results:_____ Any abnormal mammograms:_____
Date of last Gardasil injection:_____ How many injections:_____
Do you perform monthly breast exams? Y N If not, do you know how? Y N
Date of last colonoscopy (*recommended for patients who are high risk or at least 45 years old*):_____
Date of last bone scan (*recommended for patients who are high risk or at least 65 years old*):_____

OBSTETRIC HISTORY

Date of Delivery	Weight	Premature	Boy / Girl	Vaginal / C-Section	Complications
		Y N	B G	Vaginal / C-Section	
		Y N	B G	Vaginal / C-Section	
		Y N	B G	Vaginal / C-Section	
		Y N	B G	Vaginal / C-Section	
		Y N	B G	Vaginal / C-Section	
		Y N	B G	Vaginal / C-Section	

(Please continue on next page)

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PATIENT NAME:_____ DOB:___/___/_____ TODAY'S DATE:_____

MEDICAL HISTORY

Do you have any of the following (please circle):

Diabetes	Y N	Surgeries (list procedure and date):	Vaccines:
Hypertension	Y N	_____	Gardasil Y N
Cancer	Y N	_____	Shingles Y N
Stroke	Y N	_____	COVID Y N
Heart trouble	Y N	_____	Flu (seasonal) Y N
Arthritis / gout	Y N		
Convulsions	Y N	Medications (list name, dosage, and reason):	
Blood disorder(s)	Y N	_____	
Hereditary defects	Y N	_____	
Stomach ulcers	Y N	_____	
Thyroid	Y N	_____	
Other:_____		_____	

SOCIAL HISTORY

Marital status: Single____ Married____ Divorced_____ Widowed_____ Partner____

Alcohol usage: Never____ Rarely____ Moderate_____ Daily_____

Tobacco usage: Never____ Previously, but quit____ Current packs/day____

Drug usage: Never____ Type_____ Frequency_____ List all applicable_____

FAMILY MEDICAL HISTORY

Ethnicity: White___ Hispanic___ African American/Black___ Native American___ Asian___ Other:_____

Are you of Ashkenazi Jewish descent? Y N

	Age	**Medical Problems**	**If Deceased, Age at Death and Cause of Death**
Father			
Mother			
Siblings			
Spouse			
Children			

History of: Colon cancer Y N Ovarian cancer Y N Uterine cancer Y N Breast cancer Y N

PHYSICIAN SIGNATURE:_____ DATE:_____