Center for Urinary and Pelvic Disorders
S. Gregory Portera, MD, FACOG
Urogynecology

# NEW PATIENT MEDICAL HISTORY FORM

**Full Name:**_____ **DOB:**_____

**Marital status: Single Married Divorced Widowed (circle one)**

**ALLERGIES ☐ No known drug allergies (please attach separate sheet if necessary)**

| ALLERGY | ALLERGIC REACTION |
|---|---|
| | |
| | |
| | |
| | |

**MEDICATIONS (please attach a separate sheet if necessary)**

| MEDICATIONS | DOSE/TIMES PER DAY |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**HEALTH MAINTENANCE SCREENING TEST HISTORY**

| TEST | DATE PERFORMED | NORMAL? |
|---|---|---|
| Colonoscopy | | Yes No |
| Mammogram | | Yes No |
| Pap Smear | | Yes No |

**FEMALE FAMILY HISTORY**

| CONDITION | RELATION TO PATIENT |
|---|---|
| Breast Cancer | |
| Cervical Cancer | |
| Uterine Cancer | |
| Colon Cancer | |

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## Page 2

**Full Name:**_____ **DOB:**_____

## OTHER HEALTH QUESTIONS

| | |
|---|---|
| Height: | Weight: |
| Pregnancies: | Live Births: |
| Tobacco Use: Smoke Cigarettes? | Yes No If yes, packs/day: |
| Alcohol use: | Yes No |
| Recreational drug use: | Yes No |
| Sexually active: | Yes No |

## PERSONAL MEDICAL HISTORY – Check all that apply (attach a separate sheet if necessary)

| CONDITION | CURRENT | PAST |
|---|---|---|
| Hypertension | Yes No | Yes No |
| Heart Disease | Yes No | Yes No |
| Diabetes Type 1 | Yes No | Yes No |
| Diabetes Type 2 | Yes No | Yes No |
| Acid Reflux | Yes No | Yes No |
| Asthma/Lung disease | Yes No | Yes No |
| Thyroid disorder | Yes No | Yes No |
| High cholesterol | Yes No | Yes No |
| Other (please specify) | | |
| Other (please specify) | | |
| ☐ **No medical conditions** | | |

## SURGERIES – Please list all surgeries (attach a separate sheet if necessary)

| TYPE (specify left/right) | DATE | LOCATION/FACILITY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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## Page 3 – REVIEW OF SYSTEMS

Full Name:_____ DOB:_____

**Constitutional Symptoms**

| | | |
|---|---|---|
| Fever | Yes | No |
| Chills | Yes | No |
| Headache | Yes | No |
| Other: | Yes | No |

**Integumentary**

| | | |
|---|---|---|
| Skin Rash | Yes | No |
| Boils | Yes | No |
| Other: | Yes | No |
| | | |

**Eyes**

| | | |
|---|---|---|
| Blurred Vision | Yes | No |
| Pain | Yes | No |
| Other: | Yes | No |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint Pain | Yes | No |
| Back Pain | Yes | No |
| Other: | Yes | No |

**Allergic/Immunologic**

| | | |
|---|---|---|
| Hay Fever | Yes | No |
| Seasonal Allergies | Yes | No |
| Other: | Yes | No |
| | | |

**Ear/Nose/Throat**

| | | |
|---|---|---|
| Ear Infection | Yes | No |
| Sore Throat | Yes | No |
| Sinus Problems | Yes | No |
| Other | Yes | No |

**Neurological**

| | | |
|---|---|---|
| Dizzy Spells | Yes | No |
| Numbness | Yes | No |
| Tingling | Yes | No |
| Other | Yes | No |

**Genitourinary**

| | | |
|---|---|---|
| Urinary Retention | Yes | No |
| Painful Urination | Yes | No |
| Urinary Frequency | Yes | No |
| Other | Yes | No |

**Endocrine**

| | | |
|---|---|---|
| Too hot/Cold | Yes | No |
| Tired/Sluggish | Yes | No |
| Other: | Yes | No |
| | | |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Yes | No |
| Frequent Cough | Yes | No |
| Shortness of Breath | Yes | No |
| Other | Yes | No |

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | Yes | No |
| Hypertension | Yes | No |
| | | |

**Psychological**

| | | |
|---|---|---|
| Are you generally satisfied w your life? | Yes | No |
| Do you feel severely depressed? | Yes | No |
| Do you have a substance abuse problem? | Yes | No |