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

NEW PATIENT MEDICAL HISTORY FORM

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

Marital status: □ **Single** □ **Married** □ **Divorced** □ **Widowed** **(check 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 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

HEALTH MAINTENANCE SCREENING TEST HISTORY

TEST	DATE PERFORMED	NORMAL?
Colonoscopy		Yes No
Mammogram		Yes No
Pap smear		Yes No

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

NEW PATIENT MEDICAL HISTORY FORM
Page 2

Full Name:_____ **DOB:**_____

FAMILY MEMBER CANCER HISTORY

CONDITION	RELATION TO PATIENT
Breast cancer	
Ovarian cancer	
Uterine or cervical cancer	
Colon cancer	
□ None of the above in fam history	

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 I Type II (circle one)	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
Hysterectomy? (check one) □ Vaginal □ Abdominal □ Laparoscopic		
Removal of ovaries? Yes / No (circle one)		
Bladder surgery? Yes / No (circle one)		
Tubal ligation? Yes / No (circle one)		
Appendectomy? Yes / No (circle one)		
Other surgeries (please specify):		

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

NEW PATIENT MEDICAL HISTORY FORM
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