CHAMPLAIN
GYNECOLOGY
*Experienced, comprehensive & compassionate care that puts you first*

# New Patient Health History Form

*Responses on this form will help your healthcare provider get an accurate history of your medical concerns and conditions. Please answer the following questions to the best of your knowledge. You will also be asked to complete this form if it has been 3 years or more since your previous visit. Thank you!*

Date: ____ / ____ / ____

Name: _____ DOB: _____ Age: _____ Preferred Pronouns:_____
Gender Identity: _____ Occupation:_____
Do you have any drug allergies? **YES / NO** *(If yes, please list)* _____
Main reason for today's visit: _____
Please list any healthcare providers & their specialities who you see regularly, including primary care physicians:
_____
Preferred Pharmacy:_____ Address:_____

## WOMEN'S HEALTH HISTORY:

| | |
|---|---|
| What is your current method of birth control? _____ | Do you want to discuss other options? YES / NO |
| Please describe your usual period flow: | *Scant / Minimal* _____ *Moderate* _____ *Heavy* _____ |
| How painful are your periods? | *None* _____ *Mild* _____ *Moderate* _____ *Severe* _____ |
| At what age did you start your menstrual cycle? _____ | What do you use to collect period blood? _____ |
| How often do you change a pad/tampon/menstrual cup before it is full? _____ | |
| When was the first day of your last period? _____ / _____ / _____ | Do you have spotting or bleeding between periods? _____ |
| How often do your periods occur? Every _____ days | How many days do your periods last? _____ days |
| Total number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions?_____ | |

## HEALTH MAINTENANCE SCREENING TESTS: *Indicate your last screening test and results*

| Test | Date | Result (If known) |
|---|---|---|
| *Last Pap Smear* | | *Have you ever had an abnormal pap? Y/N* |
| *Recent Mammogram* | | |
| *Bone Density Test (DEXA)* | | |
| *Lipid Panel (Cholesterol) Bloodwork* | | |
| *Colonoscopy* | | |

## MEDICATIONS: *Please list all prescription and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.).*

| *Medication* | *Dose (e.g., mg/pill)* | *How many times per day?* |
|---|---|---|
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## IMMUNIZATIONS: *Write the year (if known) of any vaccinations you have had.*

☐ *Tetanus (Td)* _____ ☐ *Pneumovax (Pneumonia)* _____ ☐ *Tetanus with Pertussis (Tdap)* _____

☐ *Varicella (Chicken Pox) shot or illness* _____ ☐ *Influenza (Flu Shot)* _____ ☐ *Hepatitis A* _____ *Hepatitis B* _____

☐ *MMR (Mumps, Measles, Rubella)* _____ ☐ *HPV (Gardasil 9 Series)* _____ *Have you completed all three shots in the Gardasil 9 series?* **YES / NO**

## SOCIAL & PERSONAL RELATIONSHIPS:

Are you currently sexually active? **YES / NO**

If yes, do your partners identify as:
☐male ☐female ☐transgender male ☐transgender female ☐other

If yes, is your current partner bisexual? ***YES / NO***

Are you currently:
☐single ☐married ☐committed relationship ☐open relationship

Do you feel safe at home? **YES / NO**

Have you been sexually assaulted, abused or neglected? **YES / NO**

Do you or your partner(s) use intravenous drugs? **YES** (please specify) **/ NO**

Do you or your partner(s) smoke tobacco, marijuana, or use a vape? **YES** (please specify) **/ NO**

Do you or your partner(s) have a dependence on drugs or alcohol? **YES** (please specify) **/ NO**

Do you currently use any recreational drugs? *(If yes, please list)* _____
Have you used recreational drugs in the past? **YES / NO**
Have you ever had a problem with drug or alcohol dependence? **YES / NO**

## FAMILY MEDICAL HISTORY: *Indicate which relative has had the following diseases in the comments.*

***If you are adopted and you do not know your family history, please skip this section.***

| *Disease & Condition* | *Yes* | *No* | *Relative, Age of Diagnosis:* |
|---|---|---|---|
| *Breast Cancer* | ☐ | ☐ | |
| *Ovarian Cancer* | ☐ | ☐ | |
| *Uterine Cancer* | ☐ | ☐ | |
| *Bowel Cancer* | ☐ | ☐ | |
| *High Blood Pressure* | ☐ | ☐ | |
| *Stroke* | ☐ | ☐ | |
| *Blood Diseases* | ☐ | ☐ | |
| *Heart Attack (before age 50)* | ☐ | ☐ | |
| *Osteoporosis* | ☐ | ☐ | |
| *Thyroid Problems* | ☐ | ☐ | |
| *Other (please specify)* | ☐ | ☐ | |

## PERSONAL SURGICAL HISTORY: *Please list any recent or past surgical operations, including any complications.*

| *Operation, Surgeon* | *Year* | *Any Complications?* |
|---|---|---|
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**PERSONAL MEDICAL HISTORY:** *Do you have now or have you had (past) any of the following medical conditions? Please check the boxes "current" or "past" and include comments where applicable.*

| Medical Condition | Current | Past | Comments |
|---|---|---|---|
| Allergy (Hay Fever, Seasonal) | ☐ | ☐ | |
| Anemia | ☐ | ☐ | |
| Anxiety/Depression | ☐ | ☐ | Specify: |
| Arthritis (Osteoarthritis, Rheumatoid) | ☐ | ☐ | |
| Asthma | ☐ | ☐ | |
| Bladder / Kidney Problems | ☐ | ☐ | |
| Blood Clot (Leg, Lung) | ☐ | ☐ | |
| Blood Transfusion | ☐ | ☐ | |
| Breast Lump (benign) | ☐ | ☐ | |
| Cancer (Breast, Ovarian, Other) | ☐ | ☐ | Where? |
| Chlamydia/Gonorrhea | ☐ | ☐ | Specify: |
| Diabetes / Gestational Diabetes | ☐ | ☐ | |
| GI Issues | ☐ | ☐ | Specify: (ex. GERD, IBS, stomach ulcers) |
| Endometriosis | ☐ | ☐ | |
| Epilepsy | ☐ | ☐ | |
| Uterine Fibroids | ☐ | ☐ | |
| Heart Attack / Heart Disease | ☐ | ☐ | |
| Hepatitis (Type A, B, C, Other) | ☐ | ☐ | Specify: |
| High Blood Pressure | ☐ | ☐ | |
| Herpes (Genital or Oral) | ☐ | ☐ | Specify: |
| Liver Disease | ☐ | ☐ | |
| Migraine Headaches | ☐ | ☐ | |
| Osteopenia / Osteoporosis | ☐ | ☐ | Specify: |
| Pelvic Inflammatory Disease (PID) | ☐ | ☐ | |
| Pneumonia | ☐ | ☐ | |
| Seizure / Epilepsy | ☐ | ☐ | |
| Skin Condition (Acne, Eczema, Other) | ☐ | ☐ | Specify: |
| Stroke | ☐ | ☐ | |
| Thyroid Problems | ☐ | ☐ | Specify: (ex. Hypothyroidism, Hyperthyroidism, nodules) |
| Other (please list): | ☐ | ☐ | |