

# MEMORIAL HERMANN Medical Group

## NEW PATIENT HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: Single Married Divorced Widowed

Do you live alone: YES NO Do you have relatives in Houston: YES NO If yes who: \_\_\_\_\_

Current Problem: \_\_\_\_\_ Date problem began: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Are you allergic to any medications? YES NO \_\_\_\_\_

If yes, drug name and reaction: \_\_\_\_\_  
\_\_\_\_\_

Latex Allergy: YES NO

Have you ever been hospitalized? YES NO Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Previous surgeries: YES NO Date: \_\_\_\_\_ Surgeries: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgeries: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgeries: \_\_\_\_\_

### Menstrual History:

Date of first day of last menses: \_\_\_\_\_ Cycle Length: \_\_\_\_\_ How many days do you bleed: \_\_\_\_\_  
Periods regular: \_\_\_\_\_ Is your flow: Light Moderate Heavy Have your periods changed lately: \_\_\_\_\_  
Do you have pain with your period? YES NO If yes how much: Slight Moderate Extreme  
Do you take meds for your pain? YES NO If yes what medication do you take: \_\_\_\_\_

### Pregnancy History:

Total number of Pregnancies: \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of Miscarriages: \_\_\_\_\_ Number of abortions \_\_\_\_\_  
Tubal Pregnancy: \_\_\_\_\_ Molar Pregnancies \_\_\_\_\_  
Any complications with pregnancies: YES NO Description of problem(s): \_\_\_\_\_  
Were your deliveries all vaginal: YES NO Did you have trouble getting pregnant when you wanted to: YES NO

### Sexual History

Age at first Sexual Intercourse: \_\_\_\_\_ Are you currently (within last month) having intercourse: YES NO  
Are you satisfied with your sex life? \_\_\_\_\_  
Current Method of Contraception: \_\_\_\_\_ Have you ever used birth control pills: YES NO If yes for how long: \_\_\_\_\_

### General History

Have you ever taken female hormones: YES NO If yes for how long: \_\_\_\_\_ Name of hormone and how did you take it: \_\_\_\_\_  
Mammogram: YES NO Date: \_\_\_\_\_ Results: \_\_\_\_\_ Pap Smear: YES NO Date: \_\_\_\_\_ Results: \_\_\_\_\_  
Ever had an abnormal Pap smear: YES NO If yes when and treatment: \_\_\_\_\_  
Do you ever leak urine? YES NO Is it when you: Cough Sneeze Strain other: \_\_\_\_\_  
Do you wear protection for your clothing: YES NO  
Have you ever had an abnormal pelvic exam: YES NO Explain: \_\_\_\_\_  
Have you ever had a pelvic sonar or ultrasound: YES NO When and Results: \_\_\_\_\_  
Have you ever had a biopsy of your female organs: YES NO When and Results: \_\_\_\_\_  
Have you ever had a blood transfusion: YES NO Do you have any objections to having a blood transfusion: YES NO

Patient Name:

Date of Birth:

**HABITS**

Tobacco Use     No     Yes    Type and Amount per day \_\_\_\_\_ Age started smoking: \_\_\_\_\_  
 Alcohol Use     No     Yes    Type and Frequency \_\_\_\_\_  
 Drug Use         No     Yes    Type and Frequency \_\_\_\_\_  
 Caffeine Use     No     Yes    Type and Frequency \_\_\_\_\_

Please review the items below and indicate if you or your family has or has had any of the problems listed. Write the letter of the person who has had the issue in the box next to the problem.

(X) Self    (M) Mother    (F) Father    (G) Grandparent    (B) Brother    (S) Sister

GENERAL		PULMONARY/LUNG		LIVER		NEUROLOGICAL	
Alcoholism		Asthma		Hepatitis		Seizures	
Weight gain		Tuberculosis		<b>FEMALE ISSUES</b>			
Weight loss		Shortness of breath		Breast Cyst		<b>BLOOD</b>	
Arthritis		<b>GENITOURINARY</b>		Breast Mass		Aids/HIV	
Cancer		Blood in Urine		Vaginal Infections		Anemia	
<b>CARDIOVASCULAR</b>		Frequent Urination		<b>SEXUALLY TRANSMITTED DISEASES</b>		Bleeding Disorder	
Chest Pain		Bladder Infections		Herpes		Blood Transfusion	
Heart Failure		Kidney Stones		Syphilis		<b>GASTROINTESTINAL</b>	
Heart Murmur		<b>ENDOCRINE</b>		Gonorrhea		Black Tarry Stools	
Heart Attack		Diabetes		Chlamydia		Blood In Stool	
		Thyroid Disease		Genital Warts			
High Blood Pressure						Constipation	
Swelling of Legs/Feet						Ulcer – Gastric/ Intestinal	
Blood Clots in Legs						Diarrhea	

Is there anything else in your Medical History that you feel I should know? \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_