New Life Wellness Center

Medical History

Date ________

Last Name ________

Reason For Visit ________

First Name ________

Date of Birth ________

PCP ________

First Day of Last Menstrual Period ________

Age of First Period ________ Painful? ________

# of days from 1st day of LMP to next ________

days bleed ________ Heavy or light? ________

Last Pap ________

Last Mammogram ________

Last DEXA ________

Last Colonoscopy ________

Sexually Active? ________

If yes ________

Birth control method ________

Age of first sexual activity ________

Same partner # of years ________

Social History

Tobacco ________ Alcohol - Drinks/Week ________

Drug Use ________ Exercise ________

Marital Status ________

Abuse, ever? ________

OB History

Miscarriages ________ # Abortions ________ #Ectopic ________

Vaginal Births ________ Premature? ________

Allergies ________

Surgical History

Appendix ________ Tonsils ________ Hysteroctomy ________

Gallbladder ________ D&C ________

Medications

Medical/Family History

You		Family Member's Name	
Anemia		Anemia	
Arthritis		Arthritis	
Asthma		Asthma	
Blood Clots		Blood Clots	
Diabetes		Diabetes	
Heart Disease		Heart Disease	
Hepatitis		Hepatitis	
High Blood Pressure		High Blood Pressure	
High Cholesterol		High Cholesterol	
Intestine Problem		Intestine Problem	
Kidney Disease		Kidney Disease	
Lupus		Lupus	
Osteoporosis		Osteoporosis	
Reflux/ulcers		Reflux/ulcers	
Stroke		Stroke	
Thyroid		Thyroid	
Breast Cancer		Breast Cancer	
Ovarian/Uterine Cancer		Ovarian/Uterine Cancer	
Colon Cancer		Colon Cancer	

Review of Systems

Weight Gain		Hearing Loss		Nausea/Vomiting	
Weight Loss		Sinus Congestion		Diarrhea	
Fever		Chest Pain		Constipation	
Difficulty Sleeping		Palpitations		Vaginal Discharge	
Eyes		Cough		Low Sex Drive	

Review of Systems (Continued)

Bleeding Between Periods	________	Pelvic Pain	________	Anxiety	________
Yeast Infection	________	Breast Pain	________	Depression	________
Painful Sex	________	Breast Discharge	________	Frequent Urination	________
Skin Rash	________	Leaking of Urine	________	Heavy Vaginal Bleeding	________
Infertility	________				