STONY BROOK
Community Medical, PC

Stony Brook GYN/OB

New Patient Medical History

Name: _____ Date of Birth: ___/___/ ___ Age: ____ Sex: ____

How did you hear about our practice? _____

Pharmacy Name: _____ **Pharmacy Address:** _____

Please briefly state in the box below the reason for your visit

Past Medical History			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
☐ Breast Cancer		Other(s):	
☐ Ovarian Cancer			
☐ Heart Attack			
☐ COPD, Emphysema or Asthma			
☐ Thyroid Disease			
☐ Hypertension			
☐ Diabetes			
☐ Depression			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

Family Medical History				
Condition / Disease	***Mother***	***Father***	***Sister***	***Brother***
☐ Breast Cancer				
☐ Ovarian Cancer				
☐ Congestive Heart Failure (CHF)				
☐ Hypertension				
☐ Heart Attack				
☐ Stroke				
☐ Heart Disease				
☐ Thyroid Disease				
☐ Asthma				
☐ Depression				

Other Physicians and Specialists

Medication/Food Allergies or Intolerances *List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

Current Medications			
Medication	Dosage	Medication	Dosage

Social History	
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐	
Work Status: Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Hours worked per week:	
Do you drink alcohol? Yes ☐ No ☐	Number of drinks per week?
Are you a smoker? Yes ☐ No ☐	If yes, how many packs per day?
Are you a former smoker/former? Yes ☐ No ☐	If yes, what year did you quit?
Do you exercise? Yes ☐ No ☐	If yes duration/frequency?

GYN OB History	
First day/month of last menstrual period:	Is your period painful? Yes ☐ No ☐
Age of first menstrual period:	# of days period lasts: Cycle length:
Date of last Pap/Results:	Date of last Mammo/Results:
Age you first had intercourse:	Number of sexual partners:
Have you ever been pregnant: Yes ☐ No ☐	# of pregnancies:
Type of delivery:	Complications:
Have you ever had a STD: Yes ☐ No ☐	If you have had a STD explain:
Method of Birth Control:	Hormone Therapy: Yes No
Are you in an abusive relationship? ☐ ☐	Do you feel threatened? ☐ ☐

Additional Notes

Providers Signature: _____ Date: _____