Weill Cornell Medicine
Obstetrics & Gynecology

**Name:** _____

**MRN:** _____

**Date of Visit:** _____

**New Patient Intake Form**

Answer all questions as they apply to you. This form will be added to your medical record.

**Please select your physician.**

- o **Dr. Gelber**
- o **Dr. Grunebaum**
- o **Dr. Kalish**
- o **Dr. Landres**
- o **Dr. Lee**
- o **Dr. Pri-Paz**
- o **Dr. Sharma**
- o **Dr. Wasden**

Who referred you?_____ Primary Care Provider:_____

Age:_____ Reason for visit: _____

**Menstrual History**

Date of last menstrual period:_____ Age(yrs) at 1st period:_____ Age at Menopause:_____

My period usually occurs every _____ days and lasts for _____days.

**Please circle No or Yes**.

Heavy Periods: No Yes Painful Periods: No Yes Irregular Bleeding: No Yes PMS(bloating, moody): No Yes

**Genetic History**

Ethnic Background: _____Partner's Age & Ethnic Background:_____

**Has anyone in your family or your partner's family had any of the following? If so, please include which family member(s).**

Autism_____ Mental Retardation_____

Birth Defect _____ Muscular Dystrophy _____

Congenital Heart Disease_____ Open Spine (Bifida)_____

Cystic Fibrosis _____ Sickle Cell Anemia_____

Down's syndrome_____ Thalessemia_____

Hemophilia_____ Unexplained Fetal Loss_____

Huntington's disease_____ Other_____

**Gynecologic History**

Last Pap smear: _____ Abnormal Pap Smears: No___Yes___(Year & Treatment given) _____

Last Mammogram: _____ Abnormal Mammograms: No___Yes___(Year & Treatment given)_____

**Have you ever had any of the following infections? (Please check all that apply).**

Gonorrhea _____ Chlamydia_____ Herpes_____ Trichomonas_____ Genital Warts/HPV_____ Syphilis_____ None_____

**If so, when and how was it treated?**_____

**Have you had any of the following conditions? (Please check all that apply).**

Uterine Fibroids_____ Infertility_____ Ovarian Cysts_____ Breast disease/biopsy_____ Endometriosis_____ None_____

**If so, please detail year and how it was treated?**_____

**Contraception/Pregnancy History**

Sexually active: No Yes Medical issues pertaining to sexual activity:_____

Current method of preventing pregnancy:_____

Total number of: pregnancies _____Vaginal deliveries _____ C-Section _____ Miscarriages _____Abortions _____ Ectopic _____

Pregnancy Complications: _____

**Would you accept a blood transfusion in a life threatening situation? NO ___ YES___**

**Pregnancy History**

| Date | Delivery Type | Birth Weight | Gender/Name | Complication |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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*** **ALLERGIES: No ___ Yes ___ Please list allergies:** _____

**Medications: (List names and dosages; include vitamins, herbs, and other supplements):**

| Medication | Dosage | How Often | Medication | Dosage | How Often |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Past and Current Medical History (Please include year if diagnosis and treatment were given).**

| | | |
|---|---|---|
| _____Anemia (Blood Transfusion?) | _____Hemorrhoids | _____Neurologic Disorder |
| _____Anesthesia Complications | _____ Hiatal Hernia | _____Psychiatric Disorder |
| _____Breast disease | _____Kidney Stones | _____Seizure Disorder/Epilepsy |
| _____Congenital Heart Problem | _____Lung Disease/Asthma | _____Sickle Cell/Carrier |
| _____Diabetes | _____Lupus | _____TB/ Positive PPD |
| _____Gastrointestinal/Gallstones | _____Migraine Headaches | _____Thrombotic Disorder (Blood Clots) |

**Surgical History** (Briefly include your surgical history).

_____

_____

**Family History**

Mother: Living: Deceased (Cause): Father: Living Deceased(Cause):_____

Siblings Number Living: Number deceased: Cause: _____

**Detail below if anyone in your immediate family had the diagnosis: (Please indicate Mother, Father, Sibling, Grandparents and which side).**

| | | | |
|---|---|---|---|
| _____ Bleeding Disorder | _____ Cancer-Other | _____ High Blood Pressure | _____ Neurological Disease |
| _____ Blood Clots | _____ Diabetes | _____ High Cholesterol | _____ Psychiatric Disease |
| _____ Cancer: Breast/GYN | _____ Heart Disease | _____ Multiple Pregnancy | _____ Thyroid Disease |
| Other_____ | | | |

**Social History**

Occupation: Marital Status: Do you smoke? If so, how many packs a day?

Do you drink alcohol? No Yes If so, how many drinks/week? Do you take drugs? If so, which ones?

**Review of Systems: Are you experiencing any of the following symptoms? Please indicate all that apply or NO if they do not.**

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | No | _____Fatigue | _____Weight Loss | _____Weight Gain | _____Fever |
| **Eye Problems** | No | _____Vision Changes | _____Glasses/Contacts | | |
| **Ear, Nose, Throat** | No | _____Headache | _____Sinusitis | _____Ringing in Ears | _____Nose Bleed |
| **Cardiovascular** | No | _____Shortness of Breathe | _____Chest Pain | _____Edema | _____Palpitations |
| **Respiratory** | No | _____Wheezing | _____Coughing Blood | _____Cough | |
| **Gastrointestinal** | No | _____Nausea/vomiting | _____Constipation | _____Diarrhea | _____Bloody Stool |
| **Genitourinary** | No | _____Bloody Urine | _____Painful Urination | _____Urgency | _____Frequency |
| **Musculoskeletal** | No | _____Muscle Weakness | _____Muscle Pain | | |
| **Skin/Breast** | No | _____Breast Pain | _____Nipple Discharge | _____Breast Mass | _____Skin Rash |
| **Neurological** | No | _____Fainting | _____Seizures | _____Numbness | _____Trouble Walking |
| **Psychiatric** | No | _____Depression | _____Anxiety | | |
| **Endocrine** | No | _____Dry skin | _____Abnormal Thirst | _____Hot Flashes | |
| **Blood/Lymph** | No | _____Easy Bruising | _____Abnormal Bleeding | _____Swollen Glands | |

**Other** _____

**Reviewed By:**_____**, MD on** _____