CHICAGO
women's
HEALTH GROUP

NEW PATIENT HISTORY FORM

Name_____ Date _____

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today? _____

What are your preferred gender pronouns?

She, her, hers, herself
He, him, his, himself
They, them, theirs, themselves
Ze, hir, hirs, hirself
Just my name please
Other _____

What is your Ethnicity/Ancestry?

Ashkenazi Jewish
Asian
Black / African American
French Canadian
Hispanic / Latinx
Mediterranean
Native American or Alaska Native
Pacific Islander or Native Hawaiian
Sephardic Jewish
White / Caucasian
Other _____

What Medications are you currently taking? (Please list each medication and your current dose)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you have any of the following Health Problems?

Asthma	Y	N	Migraines / Headaches	Y	N
High Cholesterol	Y	N	Anxiety	Y	N
High Blood Pressure	Y	N	Depression	Y	N
Heart Disease	Y	N	Postpartum Depression	Y	N
Diabetes	Y	N	Other	Y	N
Thyroid Issues	Y	N	Please list: _____		

Do you have Allergies to any medications? Y N

If yes, please list: _____

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Obstetric & Gynecologic History

Date of your last menstrual period _____
Do you have any concerns about your periods? _____
Do you use a method of contraception? Y N
If yes, please indicate which type: _____
Do you have sex with men, women, or both? _____
Do you have a history of any sexually transmitted infections? Y N
If yes, please indicate which ones: _____
Date of your last Pap Smear _____
Do you have a history of abnormal pap smears? Y N
Did you receive the HPV / Gardasil vaccine? Y N
Date of your last mammogram _____
Have you had an abnormal mammogram? Y N
Have you had a breast biopsy or surgery? Y N
Have you ever been pregnant? Y N

Have you ever had any Surgery? (Please list)

1. _____
2. _____
3. _____
4. _____

Do you have a Family History of any of the following? (If yes, please list which family member)

Breast cancer	Y	N	_____	High Cholesterol	Y	N	_____
Ovarian cancer	Y	N	_____	Heart disease	Y	N	_____
Uterine cancer	Y	N	_____	Diabetes	Y	N	_____
Colon cancer	Y	N	_____	Stroke	Y	N	_____
Pancreatic cancer	Y	N	_____	Thyroid disorders	Y	N	_____
Melanoma	Y	N	_____	Bleeding Disorders	Y	N	_____
High Blood Pressure	Y	N	_____	Blood Clotting Disorder	Y	N	_____

Social History

Do you drink Alcohol? Y N
If yes, how many drinks per week? _____
Have you ever felt the need to cut down on drinking? Y N
Do you smoke Cigarettes or Vape? Y N
If yes, how many per day? _____
Do you use marijuana? Y N
Do you use any other recreational drugs? Y N
If yes, please specify _____
What is your occupation?_____
Do you exercise? Please specify how often and what type:_____
Are you currently single, in a relationship, engaged, married, divorced, or widowed? (Please circle)