



359 Centre Street Suite 1
Nutley, NJ 07110

PATIENT MEDICAL HISTORY FORM

Today's Date _____

First Name _____ Last Name _____ Date of Birth ____/____/____

Single Married Separated Divorced Widowed Livings with partner

Referred By: _____

Why have you come to the office today? _____

Is this a New Problem? _____

Please describe your problem including where it is, how severe it is, and how long it has lasted. _____

Medical History

Have you ever had any of the following?

- Anemia
- Heart Disease/Attack
- High Blood Pressure
- Stroke
- High Cholesterol
- Mitral Valve Prolapse
- Bleeding Problems
- Cancer _____
- Blood Clots in Lungs/Legs
- Gall Bladder Disease
- Liver Disease/Hepatitis
- Kidney Infections/Stones
- Bladder Infections
- Pelvic Infections
- Arthritis
- Epilepsy/Seizures/Convulsions
- Pneumonia/Lung Disease
- Tuberculosis
- Migraines/Headaches
- Depression/Anxiety
- Drug or Alcohol Problem
- Diabetes
- Asthma
- Chicken Pox
- Bowel Problems
- Sickle Cell Disease
- Thyroid Problem
- Blood Transfusion
- Genetic Condition
- Eating Disorder

- Breast Cancer If yes, at what age _____ Check if both breasts or multiple reoccurrences
- Colon Cancer If yes, at what age _____ Check if multiple reoccurrences
- Uterine Cancer If yes, at what age _____ Check if multiple reoccurrences
- Ovarian Cancer If yes, at what age _____

List all **medications** you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

Allergies to medications and or foods _____ No Known Allergies

Surgical History

Please list all surgeries with dates:

Obstetrical History Please list all pregnancies (miscarriages, stillbirths, ectopics (tubal), & abortions)

		Number				Number	
Pregnancies				Abortions			
Premature Births (less than 37 weeks)				Live Births		Living Children	
Year	M/F	Type of Delivery	Week Pregnant	Weight at Birth	Problems (e.g., preterm labor, diabetes, high blood pressure)	Name/Age	

Gyn History

Age of first period _____ Periods are: Regular Irregular Painful Not really bothersome
 Flow is: Light Light to moderate Moderate to heavy Very heavy
 Age of last period _____
 Cycle length: every _____ days lasting _____ days
 Have you ever had sex? Yes No Are you currently sexually active? Yes No
 Sexual preference: Men Women Both
 New partner(s)? Yes No Number of lifetime partners _____

Method of Birth Control: Condoms Pills Patch Vaginal Ring Tubal/Essure IUD Partner with vasectomy Natural family planning Other None

Have you ever had any of the following STDs? Chlamydia Gonorrhea Herpes Never had any HPV Syphilis Trichomonas HIV Hepatitis B Hepatitis C

Have you ever had any of the following? Fibrocystic breasts Ovarian cysts Endometriosis Uterine fibroids

Do you perform regular breast self examination? Yes No

Date of last pap smear _____ Normal Abnormal

Have you ever needed any of the following for an abnormal pap? Colposcopy Cryosurgery LEEP/Laser/Conization No

Date of last mammogram _____ Normal Abnormal Never had one

Date of last bone density _____ Normal Osteopenia Osteoporosis Never had one

Date of last colonoscopy _____ Never had one

Family History

Please list any close relatives with a history of the following:

- Breast Cancer If yes, at what age _____ Check if Both Breasts or multiple reoccurrences
- Colon Cancer If yes, at what age _____ Check if multiple reoccurrences
- Uterine Cancer If yes, at what age _____ Check if multiple reoccurrences
- Ovarian Cancer If yes, at what age _____

	Relative		Relative
<input type="checkbox"/> Alzheimer's		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Mental Illness/ Depression		<input type="checkbox"/> Heart Disease (heart attack Stroke, bypass surgery)	
<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Other _____	

Social History

- Seat Belt Use Yes No
- Alcohol Use Yes No If yes, _____ drink(s) per day/week/month
- Tobacco Use Yes No If yes, _____ pack(s) per day for _____ years
- Drug Use Yes No Type and frequency _____
- Exercise Yes No Type and frequency _____
- Caffeine Yes No If yes, _____ caffeinated drinks (coffee, tea, soda) per day/week
- Sexual Abuse Yes No If yes, are you safe now? Yes No Counseling? Yes No
- Physical Abuse Yes No If yes, are you safe now? Yes No Counseling? Yes No
- Emotional Abuse Yes No If yes, are you safe now? Yes No Counseling? Yes No

Review of Systems

Do you currently have any of the following?

	Comments		Comments
<input type="checkbox"/> Yes <input type="checkbox"/> No Generally healthy		<input type="checkbox"/> Yes <input type="checkbox"/> No Frequent urination	
<input type="checkbox"/> Yes <input type="checkbox"/> No Recent weight gain or loss of 25 lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No Burning with urination	
<input type="checkbox"/> Yes <input type="checkbox"/> No Fever		<input type="checkbox"/> Yes <input type="checkbox"/> No Incontinence	
<input type="checkbox"/> Yes <input type="checkbox"/> No Vision problems		<input type="checkbox"/> Yes <input type="checkbox"/> No Urgency	
<input type="checkbox"/> Yes <input type="checkbox"/> No Sinus problems		<input type="checkbox"/> Yes <input type="checkbox"/> No Bladder infection	
<input type="checkbox"/> Yes <input type="checkbox"/> No Hearing loss		<input type="checkbox"/> Yes <input type="checkbox"/> No Stomach pains	
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain		<input type="checkbox"/> Yes <input type="checkbox"/> No Vaginal discharge	
<input type="checkbox"/> Yes <input type="checkbox"/> No Varicose veins		<input type="checkbox"/> Yes <input type="checkbox"/> No Irreg vagina bleeding	
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath		<input type="checkbox"/> Yes <input type="checkbox"/> No Pelvic pain	
<input type="checkbox"/> Yes <input type="checkbox"/> No Chronic cough		<input type="checkbox"/> Yes <input type="checkbox"/> No Painful intercourse	
<input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea		<input type="checkbox"/> Yes <input type="checkbox"/> No Breast lumps	
<input type="checkbox"/> Yes <input type="checkbox"/> No Constipation		<input type="checkbox"/> Yes <input type="checkbox"/> No Back pain	
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood in stools		<input type="checkbox"/> Yes <input type="checkbox"/> No Joint/muscle pain	
<input type="checkbox"/> Yes <input type="checkbox"/> No Heartburn/reflux		<input type="checkbox"/> Yes <input type="checkbox"/> No Depression/anxiety	
<input type="checkbox"/> None of the above		<input type="checkbox"/> None of the above	

Patient Signature _____ Date _____

Clinician Signature _____ Date _____

Annual Review #2 Clinician Signature _____ Date _____

Annual Review #3 Clinician Signature _____ Date _____



Obstetrics & Gynecology

359 Centre Street Suite 1
Nutley, NJ 07110

PATIENT REGISTRATION FORM

Today's Date _____

First Name _____ Last Name _____ Date of Birth ____/____/____

Is this your legal name? Yes No If not, what is your legal name? _____

Single Married Separated Divorced Widowed Livings with partner

Street address: _____ City: _____ State: _____ Zip code: _____

Social Security no.: _____ - _____ - _____ Home phone: _____ Cell phone: _____

Email: _____ Employer: _____ Employer phone: _____

Referred by (please check one box): Dr. _____ Insurance Plan Hospital
Family Friend Close to home/work Internet Other: _____

Insurance Information

(Please give your insurance card to the receptionist)

Person responsible for bill: _____ Address (if different): _____

City: _____ State: _____ ZIP Code: _____ Home phone no.: _____

Are you covered by insurance? Yes No Please indicate primary insurance: _____

Relationship to subscriber Self Spouse Child Other _____

Subscriber's name: _____ Subscriber's S.S.: _____ - _____ - _____ Birth date: ____/____/____

Group no.: _____ Policy no.: _____

Occupation: _____ Employer: _____

Employer address: _____ Employer phone no.: _____

Do you have secondary insurance? Yes No Please indicate primary insurance: _____

Relationship to subscriber Self Spouse Child Other _____

Subscriber's name: _____ Subscriber's S.S.: _____ - _____ - _____ Birth date: ____/____/____

Group no.: _____ Policy no.: _____

Occupation: _____ Employer: _____

Employer address: _____ Employer phone no.: _____

In Case Of Emergency

Name: _____ Relationship to patient: _____

Home phone: _____ Work phone: _____ Cell phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Bestcare OB/GYN. I understand that I am financially responsible for any balance. I also authorize Bestcare OB/GYN or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date _____