Return via fax to the appropriate number below.

WEILL CORNELL MEDICAL ASSOCIATES

EAST SIDE
201 E 80TH ST
Fax: 646-962-0501

WEST SIDE
12 W 72ND ST
Fax: 646-962-0502

New Patient Medical History Form

Please answer all that apply to you. This form will be added to your medical record.

Name: ____ **Date :**__________________

Primary Care Provider ___________________________ **Age :**_______________

Who referred you? ______________________
Reason for visit:

Menstrual history**:**
Date of last menstrual period: _______________
Age at first period: _______________
My period usually occurs every_______ days/weeks
My period usually lasts for_______ days
My period usually *(circle one)* is / is not painful. My period usually *(circle one)* is / is not heavy.
My period is unusual or irregular as described here:_____________________________________
____

Age at menopause: _______________

If you are menopausal: Are you on hormone replacement therapy? [ ] yes [ ] no
Type and dose: _____________________________________

Gynecologic History:

Date of last pap smear: _______________
Have you ever had abnormal pap smears ? [ ] yes [ ] no
If yes, year and treatment given:____

Date of most recent mammogram: _______________
Have you ever had an abnormal mammogram? [ ] yes [ ] no
If yes, detail here:____

Have you ever required a breast sonogram? [ ] yes [ ] no
Do you perform monthly breast self exams? [ ] yes [ ] no

If yes, have you ever felt a lump or irregularity? ____

Have you had any of the following gynecologic infections?
[ ] none yeast [ ] bacterial vaginosis (gardnerella) [ ] gonorrhea [ ] chlamydia [ ]herpes
[ ] trichomonas [ ] genital warts (HPV) [ ] syphilis
If yes, please detail year and treatment given: ____

Have you ever had an infection in your Fallopian tubes or ovaries (PID)? [ ] yes [ ] no
If yes, please detail year and treatment given:
____

Have you had fibroids? [ ] yes [ ] no

If yes, treatment given:____

Have you had ovarian cysts? [ ] yes [ ] no
If yes, detail year and treatment:
____
____

Are you currently having sex? [ ] yes [ ] no
If so, are you experiencing any problems?____
____

My current method of preventing pregnancy is:____
Other methods of contraception that you have used:
[ ] birth control pills [ ] IUD [ ] condoms [ ] spermacide [ ] depo-provera [ ] norplant [ ] diaphragm
[ ] natural family planning (rhythm) [ ] withdrawal [ ] cervical cap
Have you had any problems with these methods?
____

Are you aware that condoms help prevent sexually transmitted diseases? [ ] yes [ ] no
When were you last tested for HIV? _______________________
Would you like to be tested for HIV today? [ ] yes [ ] no

Obstetrical history:
Total number of pregnancies____ Vaginal deliveries_____ C/sections______ miscarriages________
Abortions_____ Ectopic _______
Pregnancy complications:____
____

Medical problems: (either now or in the past/Detail below with year of diagnosis and treatment given)

[ ]anemia
[ ]anxiety / depression
[ ]bleeding disorder
[ ]breast disease
[ ]cancer (specify)
[ ]cataracts
[ ]diabetes
[ ]gallstones
[ ]heart attack
[ ]hemorrhoids
[ ]other:
[ ]hepatitis/jaundice/liver disease
[ ]hiatal hernia
[ ]hypertension
[ ]incontinence
[ ]irritable bowel
[ ]kidney stones
[ ]frequent bladder infections
[ ]lung disease / asthma
[ ]migraines / headaches
[ ]mitral valve prolapse/ heart murmur
[ ]pneumonia/ bronchitis
[ ]seizure disorder / epilepsy
[ ]sexual problems
[ ]sickle cell / carrier
[ ]stroke
[ ]thalassemia
[ ]thrombotic disorder (blood clot
[ ]thyroid (high/ low)
[ ]urinary incontinence
[ ]varicose veins / thrombophlebitis

Detail:____
____

Surgical history:

Name of Procedure	Date of Procedure:	Reason for Procedure
1.		
2.		
3.		
4.		

Current medications: (include name of medication, dosage and how often taken)

1 4

2 5

3 6

Are you allergic to any medications? [ ] yes [ ] no
If yes, medication and reaction: ____
____

Family History:

Yes	No		Yes	No	
[ ]	[ ]	Breast cancer	[ ]	[ ]	Diabetes
[ ]	[ ]	Ovarian cancer	[ ]	[ ]	Kidney Disease
[ ]	[ ]	Uterine cancer	[ ]	[ ]	High Blood Pressure
[ ]	[ ]	Colon cancer	[ ]	[ ]	Heart Disease
[ ]	[ ]	Thyroid cancer			

Other____

Social History:
Occupation_____________________________ Marital Status________________________________

[ ] yes [ ] no Smoking list # packs per day and # years)___________________
[ ] yes [ ] no Alcohol: (list how much and how often) ___________________
[ ] yes [ ] no Marijuana or other drugs: ___________________

Health Maintenance:	Yes	No
Are you immune to rubella, chicken pox, and hepatitis B?	[ ]	[ ]
Have you been exposed to people with tuberculosis?	[ ]	[ ]
Do you work in a health care facility?	[ ]	[ ]
If you are a candidate, are you interested in receiving the influenza vaccine (flu shot)?	[ ]	[ ]
Have you had a tetanus diptheria booster within the last 10 years?	[ ]	[ ]
When was the last time you had your cholesterol level checked?	[ ]	[ ]

Please list any additional information that you feel is relevant:

Physicians notes: