SWING WOMEN'S HEALTH AND WELLNESS

NEW PATIENT FORM

Name_____ Age _____ Today's date _____

Date of Birth _____ Email_____

Address _____ City _____ State _____ Zip_____

Phone (Home) _____ (Cell)_____ (Work) _____

Emergency contact _____ Relationship _____

Phone (Home) _____ (Cell)_____ (Work) _____

Health insurance _____ Group/Policy number _____

Pharmacy name _____ Pharmacy number _____

How did you hear about this practice? _____

What is the main reason you are here today? _____

_____

_____

Who is your primary care physician? _____

GENERAL HEALTH MAINTENANCE

	Date	Normal	Abnormal	Comments
Last Pap Smear	_____	_____	_____	_____
Last mammogram	_____	_____	_____	_____
Last colonoscopy	_____	_____	_____	_____
Last bone density	_____	_____	_____	_____
Annual bloodwork	_____	_____	_____	_____

VACCINATIONS

	Date	Date	Date
HPV (Gardasil)	_____	_____	_____
Tdap (whooping cough/tetanus)	_____		
Measles-mumps-rubella (MMR)	_____		

	Date	Date	Date
Influenza	_____		
Shingles	_____	_____	
Pneumococcal (pneumonia)	_____	_____	
COVID-19	_____	_____	_____
	_____		

SOCIAL HISTORY

Current contraception (please include date of placement for device or date of procedure):

_____

Marital status: ____Single ____Married ____Divorced ____Widowed

Are you sexually active? _____Yes _____No

_____Men _____Women _____Both

What is your current occupation? _____

Do you currently smoke? _____ Yes _____ No

If so, how many cigarettes per day? _____

Have you ever smoked?

If so, for how many years and when did you stop smoking? _____

Do you drink alcohol? _____ Yes _____ No

If so, how many drinks do you consume per week?

_____Glasses of wine _____Cans of beer

_____Shots of liquor _____Drinks containing 0.5 oz of alcohol

Do you use recreational drugs? _____ Yes _____ No

If so, which ones and how often? _____

_____

Exercise	Type	# of times per week	Duration (minutes)
Cardio/Aerobic	_____	_____	_____
Resistance/Strength	_____	_____	_____
Flexibility/Stretching	_____	_____	_____
Balance	_____	_____	_____

Please describe any other type of exercise / physical activity you participate in including the type, number of times per week, and duration of activity. _____

_____

Do you feel you have excessive amounts of stress in your life? _____Yes _____No

Do you participate in mindfulness relaxation activities? _____Yes _____No

If so, what type and how often? _____

Do you feel you can easily handle the stress in your life? _____Yes _____No

How much stress do each of the following cause you daily? (Please rate 1-10, 10 being the highest)

____Work ____Family ____Social ____Finances ____Health ____Other

How many hours of sleep do you get every night? _____

Do you have a regular sleep routine? _____Yes _____No

If so, please describe_____

Do you have problems falling asleep? _____Yes _____No

Do you have problems staying asleep? _____Yes _____No

Do you feel rested upon awakening? _____Yes _____No

Do you use sleeping aids? _____Yes _____No

If so, please explain_____

_____

How many ounces of water do you drink daily? _____

Please describe your dietary habits_____

_____

_____

ALLERGIES

Medication	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

	Yes	No	Reaction
Latex	_____	_____	_____
Iodine/seafood	_____	_____	_____

Other allergies_____

_____

MEDICATIONS

Name	Dosage	When and how many times per day taken?

SUPPLEMENTS

Name	Dosage	When and how many times per day taken?

GYNECOLOGIC HISTORY

Age of first period_____ First day of last menstrual period _____

How often do you get a period? _____

How many days do your periods last? _____

Do you bleed between periods? _____ Do you bleed / spot after sex? _____

Is your menstrual flow light, moderate, or heavy? _____

Do you pass clots? _____ Are your periods painful? _____

If yes, how painful are they on a scale of 1 – 10 with 10 being the worst? _____

Have you ever had sex? _____ Are you currently sexually active? _____

Have you ever had an abnormal Pap smear? _____ Yes _____ No

If so, when? _____

If you are menopausal:

How old were you when you had your last period? _____

Have you experienced any bleeding following 1 full year without a period? ____Yes ____No

Have you ever been diagnosed with any of the following?

Condition	**Yes**	**No**
Endometriosis	_____	_____
PCOS	_____	_____
Fibroids	_____	_____
DES exposure	_____	_____
Infertility	_____	_____
HPV (human papillomavirus)	_____	_____
Chlamydia	_____	_____
Gonorrhea	_____	_____
Trichomonas	_____	_____
HIV	_____	_____
Syphilis	_____	_____
Hepatitis	_____	_____

OBSTETRICAL HISTORY

Number of vaginal deliveries_____ Number of cesarean deliveries_____

Lowest infant birth weight_____ Highest infant birth weight_____

Complications during pregnancy or delivery_____

_____

Do you have a PERSONAL history of the following?

	Yes	No		Yes	No
Cardiovascular					
High blood pressure	_____	_____	High cholesterol	_____	_____
Heart attack	_____	_____	Coronary artery disease	_____	_____
Mitral valve prolapse	_____	_____	Aortic valve disease	_____	_____
Atrial fibrillation	_____	_____	Congestive heart failure	_____	_____
Other cardiovascular diseases _____					
Respiratory					
Asthma	_____	_____	Emphysema	_____	_____
COPD	_____	_____	Bronchitis	_____	_____
Sinusitis	_____	_____	Sleep apnea	_____	_____
Other respiratory diseases _____					
Endocrine					
Diabetes	_____	_____	Hypothyroidism	_____	_____
Hyperthyroidism	_____	_____	Addison's disease	_____	_____
Cushing's Disease	_____	_____	Hypoparathyroidism	_____	_____
Hyperparathyroidism	_____	_____	Vitamin D deficiency	_____	_____
Other endocrine disorders _____					
Rheumatologic					
Rheumatoid arthritis	_____	_____	Systemic lupus erythematosus	_____	_____
Sjogren's disease	_____	_____	Polymyalgia rheumatica	_____	_____
Hashimoto's disease	_____	_____	Grave's disease	_____	_____
Other autoimmune disease_____					
Gastrointestinal					
Acid reflux	_____	_____	Peptic ulcer disease	_____	_____
Hepatitis (A,B,C,D,E)	_____	_____	Fatty liver disease	_____	_____
Liver cysts	_____	_____	Liver hemangiomas	_____	_____
Gallstones	_____	_____	Irritable bowel syndrome	_____	_____

	Yes	No		Yes	No
Crohn's disease	_____	_____	Ulcerative colitis	_____	_____
Celiac disease	_____	_____			

Other gastrointestinal disease_____

Urologic

Kidney stones	_____	_____	Ureteral stones	_____	_____
Chronic renal failure	_____	_____	Renal cysts	_____	_____
Pelvic kidney	_____	_____	Absent kidney	_____	_____
Interstitial cystitis	_____	_____	Recurrent UTIs	_____	_____
Urinary incontinence	_____	_____			

Other urologic disorders_____

Hematologic / Cancer

Anemia	_____	_____	History of blood transfusion	_____	_____
DVT (blood clot in leg)	_____	_____	PE (blood clot in lung)	_____	_____
Clotting disorder	_____	_____			

If yes, do you know what genetic mutation you have? _____

Cancer _____ _____

If yes, which type of cancer did you have, when were you diagnosed, and what treatment did you receive? _____

_____

_____

_____

Other hematologic disorders_____

Musculoskeletal

Osteoarthritis	_____	_____	Osteopenia	_____	_____
Osteoporosis	_____	_____	Fibromyalgia	_____	_____
Bone fractures	_____	_____			

Other musculoskeletal disorders _____

	Yes	No		Yes	No
Neurologic					
Migraine headaches	_____	_____	Seizure disorder	_____	_____
Stroke	_____	_____	Alzheimer's disease	_____	_____
Dementia	_____	_____	Parkinson's disease	_____	_____
Multiple sclerosis	_____	_____	Myasthenia gravis	_____	_____
ALS	_____	_____	Glaucoma	_____	_____
Psychiatric					
Depression	_____	_____	Anxiety	_____	_____
Panic disorder	_____	_____	ADHD / ADD	_____	_____
Bipolar disorder	_____	_____	Schizophrenia	_____	_____
Bulimia	_____	_____	Anorexia nervosa	_____	_____

Other psychiatric disorders_____

Please list any other medical conditions not listed above_____

_____

_____

SURGICAL HISTORY

Year	Type of Surgery	Complications

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

(Please specify paternal or maternal grandfather, grandmother, father, mother, brother, sister, uncle or aunt)

Breast cancer_____

Ovarian cancer_____

Endometrial cancer_____

Colon cancer_____

Hypertension_____

Coronary artery disease_____

Heart attack_____

Stroke_____

Blood clot in leg/lung_____

Bleeding disorder_____

Alzheimer's disease_____

Dementia_____

High cholesterol_____

Diabetes mellitus_____

Obesity_____

Hypothyroidism_____

Hyperthyroidism_____

Kidney disease_____

Liver disease_____

Genetic disease (please specify)_____

Other medical problems or cancer (please specify)_____

_____

Father _____Alive _____Deceased

Cause of death_____

Mother _____Alive _____Deceased

Cause of death_____

Paternal grandfather _____Alive _____Deceased

Cause of death_____

Paternal grandmother _____Alive _____Deceased

Cause of death_____

Maternal grandfather _____Alive _____Deceased

Cause of death_____

Maternal grandmother _____Alive _____Deceased

Cause of death_____

Brothers _____Number alive _____Number deceased

Cause(s)_____

Sisters _____Number alive _____Number deceased

Cause(s)_____

REVIEW OF SYSTEMS

	Yes	No		Yes	No
Headache	_____	_____	Diarrhea	_____	_____
Dizziness	_____	_____	Constipation	_____	_____
Numbness or tingling	_____	_____	Nausea	_____	_____
Hearing loss	_____	_____	Vomiting	_____	_____
Vision problems	_____	_____	Pain with urination	_____	_____
Distorted sense of taste	_____	_____	Frequent urination	_____	_____
Distorted sense of smell	_____	_____	Low back pain	_____	_____
Fatigue	_____	_____	Cold hands or feet	_____	_____
Moodiness	_____	_____	Cold intolerance	_____	_____
Breast tenderness	_____	_____	Heat intolerance	_____	_____
Chest pain	_____	_____	Vaginal discharge	_____	_____
Shortness of breath	_____	_____	Vaginal itching	_____	_____
Heart palpitations	_____	_____	Rash	_____	_____
Panic attacks	_____	_____	Itchy skin	_____	_____

Please list any other pertinent symptoms_____

_____

_____