Nezhat Surgery for
Gynecology / Oncology

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NEW PATIENT HISTORY FORM

Name: _____ Referring Physician: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Telephone Home: _____ Work: _____ Cellphone: _____

Occupation: _____

Marital Status: _____

Person to Notify in case of Emergency: _____

Relationship: _____ Phone Number: _____

Reason or Today's Visit: _____

PAST OB/GYN HISTORY:

Date of Last Menstrual period:

Date of Mammogram:

Current Method of Birth Control:

Hormone Replacement Therapy:

Total Number of Pregnancies: Number of Living Children:

Full term: Premature: Miscarriages: Voluntary abortions:

Menstrual history: Age of onset of Mentrual periods:

Age of Menopause:

Periods occur every _____ days

	Yes	No
Bleeding between periods?		
Pain with periods?		
Menopausal symptoms?		
Experiencing vaginal discharge or itch?		
Significant premenstraual symptoms?		

Pap smear history: Date of last pap smear _____

Result of last pap smear? _____

Did your mother take DES during pregnancy? _____ _____

Have you ever had an abnormal pap smear? _____ _____

Please describe? _____

Sexual history: Age of first intercourse: _____ 19 or younger _____ 20 or older

Total sexual partners: _____ fewer than 3 _____ more than 3

If you are not sexually active, you may leave the next section blank:

	Yes	No
Pain with intercourse?	_____	_____
Bleeding after intercoure?	_____	_____
Have you had a sexually transmitted infection?	_____	_____
please describe:		
Have you had any ontacts/exposures to HIV?	_____	_____
Do you have problems with sex?	_____	_____
please describe:		

PAST MEDICAL HISTORY: Please describe any current past medical conditions:

☐	High blood pressure	☐	Diabetes
☐	High cholesterol	☐	Blood clots
☐	Heart attack	☐	Stroke
☐	Asthma	☐	Thyroid problems
☐	Depression	☐	Anxiety
☐	Cancer, type:		

Other conditions or hospitalizations:

_____

_____

PAST SURGICAL HISTORY: Please describe any minor or major procedures you have undergone:

_____

_____

_____

FAMILY HISTORY: Please list any serious illnesses and age of onset. Indicate age and cause of death if applicable.

Mother: _____

Father: _____

Sisters: _____

Brothers: _____

Anyone in family with breast, ovarian, colon, or uterine cancer? _____

Other cancers? _____

☐	Osteoperosis	☐	Hip fractures	☐	Inherited diseases i.e. hemphilia, cystic fibrosis
☐	Birth defects	☐	Stillborn infants		

If you are African-American-genetic testing (i.e ickle cell trait)? _____

If you are of Jewish descent - genetic testing (i.e Tay Sachs disease)? _____

SOCIAL HISTORY:

Occupation:

Marital Status:

Alcoholic drinks per week:

Cigarettes per day:

Past or current drug use:

regular exercise:

MEDICATIONS:

ALLERGIES:

Medications and Reactions:

Foods:

☐	Latex	☐	Iodine
☐	Shellfish	☐	IV contrast

BRIEF REVIEW OF SYSTEMS:

General:	☐	Weight loss	☐	Weight gain
	☐	Bloating	☐	Decreased appetite
Nervous System:	☐	Multiple Sclerosis	☐	Seizures
	☐	Blind Spots	☐	Migraines
Respiratory System:	☐	Coughing up blood	☐	Cough
Cardiovascular System:	☐	Chest pain with exertion	☐	Unexplained shortness of breath
	☐	Sleeping on more than one pillow		
Gastrointestinal System:	☐	Blood in bowel movements	☐	Diarrhea
	☐	Constipation		
Urinary System:	☐	Bladder infections	☐	Blood in urine
	☐	Burning on urination	☐	Leaking urine
Musculoskeletal System:	☐	Numbness	☐	Weakness
	☐	Arthritis		

Thank you for taking the time to provide us with an accurate medical history.

To protect patient privacy and confidentiality, we ask that you do not scan and email us these forms. If you need to share sensitive information, we can be reached by telephone, fax, or mail. Feel free to contact our office anytime at (646) 970-2737 or (516) 663-1365. We can be reached via fax at (866) 996-8415.