Nezhat Surgery for
Gynecology / Oncology
Farr Nezhat MD FACOG FACS

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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., sickle cell trait)? _____

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

SOCIAL HISTORY:

Occupation: _____

Marital Status: _____

Alcoholic drinks p/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.**