



Center for Pelvic Health

A Member of Saint Thomas Health Services

New Patient Form

Preferred Day time phone: _____

Pharmacy name and number: _____

Marital Status: _____

Occupation: _____

Who do you live with: _____

Do you use tobacco? Yes No If yes, how many packs per day? _____

Drink alcohol? Yes No If yes, how often? _____

Use recreational drugs? Yes No

Who referred you to our office? _____

What brings you to the office today? _____

PAST MEDICAL HISTORY (Please answer all questions with YES or NO)

Asthma	Yes No	Endometriosis	Yes No	Blood Clots	Yes No	Thyroid disease	Yes No
High blood pressure	Yes No	Anemia	Yes No	Heart disease	Yes No	Abnormal pap smears	Yes No
Strokes	Yes No	Back Injury	Yes No	Cancer	Yes No	Migraines	Yes No
Diabetes	Yes No	Kidney disease/ stones	Yes No	Osteoporosis	Yes No	Sexually transmitted infections	Yes No

ADDITIONAL: _____

PAST SURGICAL HISTORY (Please list and give dates) _____

REVIEW OF SYSTEMS (Please answer all questions with YES or NO if you have experience these symptoms recently)

Constitutional

Weakness Yes No
 Chills Yes No
 Fever Yes No
 Weight change Yes No

Respiratory

Shortness of breath Yes No
 Coughing blood Yes No
 Wheezing Yes No
 Nose bleeds Yes No

Neurologic

Headaches Yes No
 Fainting spells Yes No
 Memory loss Yes No
 Numbness/ tingling Yes No

Eyes

Glasses/contacts Yes No
 Double vision Yes No
 Blurry vision Yes No

Cardiac

Chest pain Yes No
 Swelling Yes No
 Irregular heart beat Yes No

Skin

Rash Yes No
 Hair growth/loss Yes No
 Pigment changes Yes No

Psychiatric

Depression Yes No
 Mood changes Yes No
 Anxiety Yes No

Musculoskeletal

Joint pain Yes No
 Muscle weakness Yes No
 Unsteady gait Yes No

Endocrine

Heat/cold intolerant Yes No
 Excessive thirst Yes No
 Increased urination Yes No

Ear, Nose, Throat

Hearing change Yes No
 Sore throat Yes No
 Sinus pain Yes No

Gastrointestinal

Diarrhea Yes No
 Constipation Yes No
 Heartburn Yes No

Genitourinary

Frequent bladder infections Yes No
 Painful urination Yes No
 Blood in urine Yes No

Hematologic: Bleeding Yes No Bruising Yes No

List your medications, dose and how often you take them: _____

List your Allergies to medicines: _____

FAMILY HISTORY (Please answer all questions with YES or NO and list family member affected)

Asthma	Yes No	Who? _____	Tuberculosis	Yes No	Who? _____	High blood pressure	Yes No	Who? _____
Heart disease	Yes No	Who? _____	Strokes	Yes No	Who? _____	Cancer	Yes No	Who? _____
Diabetes	Yes No	Who? _____	Kidney disease	Yes No	Who? _____	Osteoporosis	Yes No	Who? _____

ADDITIONAL: _____

Patient Signature: _____

Date: _____

MD/APN Signature: _____

Date: _____

I have reviewed this history and have confirmed it.