

NEW PATIENT INFORMATION SHEET

Please print your name below:

Please print today's date:

Please state briefly the nature of today's visit:

How did you hear about Dr. Turner's office?

Medical/Surgical History

1. Do you have any of the following medical problems? (circle all that apply)

Asthma/Lung Disease
 Diabetes
 Heart Disease
 Circulatory Problems
 Hypertension
 Seizure Disorder

Arthritis
 Stroke
 Liver Disease/Hepatitis
 Ulcers
 GI Problems
 Blood Clots

2. Do you have any allergies to medications or foods? (if so, please list them below)

3. Do you take any medications? (Please list all medications below including those that are over-the-counter or herbal medications)

4. Have you ever had any surgical procedures? (if so, please list them below with their dates)



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Obstetrical History

1. How many children do you have? _____

Please give details of all deliveries you have experienced below.

Child's First Name & Sex (M/F)	Child's birthday	Weight (in pounds)	Vaginal/Cesarean	Hospital	Type of anesthesia

2. Have you ever had a miscarriage? Yes / No
If yes, how many _____

3. Have you ever had an abortion? Yes / No
If yes, how many _____

4. Have you ever had an ectopic (tubal) pregnancy? Yes/No
If yes, how many _____

Gynecologic History

1. Have you ever had a pap smear that was *NOT* normal? Yes / No

2. Have you ever used an IUD? Yes / No

3. Have you ever been treated for a sexually transmitted infection? Yes / No
If yes, which one? (circle all that apply)

- Herpes
- Syphilis
- Trichomonas
- Hepatitis B
- HPV/ genital warts
- HIV
- Gonorrhea
- Chlamydia



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4. Are you currently sexually active? Yes / No

If no, have you ever been sexually active? Yes/No

If yes, are you currently in a mutually monogamous relationship? Yes/No

Do you have sex with men/women or both? _____

What type of contraception do you use? (circle below)

Condoms

Birth Control Pills

Contraceptive Patch

Contraceptive Ring

Norplant

IUD

Diaphragm

Tubal ligation

None

Husband/Partner had vasectomy

5. Are you experiencing any problems with your menstrual period? Yes/ No

6. Are you experiencing any menopausal symptoms? Yes/No

7. How old were you when you got your first menstrual period? _____

8. How old were you when you became sexually active? _____

9. How many sexual partners have you had in your lifetime? 1-4 5-10 more than 10

Social History

1. Are you married? Yes / No

2. Do you smoke cigarettes? Yes / No

3. Do you drink alcohol? Yes / No

4. Do you use illegal drugs? Yes / No

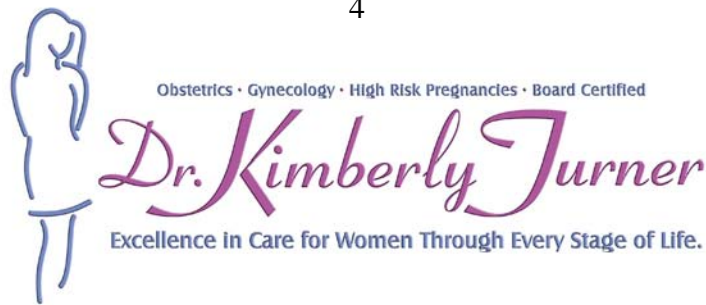
5. Do you work outside the home? Yes / No

What type of work do you do? _____

6. Do you have pets inside your home? Yes / No

If yes, what type of pets do you have? _____

7. What is your race/ethnic background? _____



Review of Systems

Are you currently experiencing any of the following symptoms? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Heat/Cold Intolerance Cough | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Blood in urine Memory Loss |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Increased Hunger |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Increased Thirst |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Heavy Menstrual Cycles |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Constipation | |



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Family History

1. Do any of the following conditions occur in your family? (circle all that apply)

Hypertension

Diabetes

Stroke

Circulatory Problems

Mental Retardation

Down's Syndrome

Sickle Cell Anemia

Huntington's Disease

Cystic Fibrosis

Marfan's Syndrome

Cardiac Disease

Kidney Disease

Cancer/Breast Cancer

Uterine Fibroids

Endometriosis

Other

2. Please list the age of each living first degree relative below and their medical diagnoses if any

(Relative)	(Age)/s	(Medical Diagnoses)
Father		
Mother		
Sister(s)		
Brother(s)		
Child/Children		

Do you have a religious preference? Yes/No.

If yes, please specify which religion. _____

I certify that the information above is accurate and complete:

Patient Signature: _____

I certify that I have reviewed the information:

Practitioner's Signature: _____