Haydee Docasar, M.D.

www.haydeedocasarmd.com

NEW PATIENT HISTORY

I. Identifying Information

Name: _____ DOB: _____ Date: _____
Reason for visit_____
Age: _____ Marital Status: _____ Occupation: _____
Who referred you? _____
Name of internist or family doctor: _____
Spouse/Partner's name: _____ Occupation: _____
List any other physicians or health care providers you see:
_____

II. Medical History □ None

Please list any medical problems that you have.
_____
_____
_____

Have you had any hospitalization, injuries, fractures or motor vehicle accidents? □ None
_____
_____

Check if you have or have you ever had:

□ Alcohol abuse	□ Anesthetic reaction	□ Bleeding disorder
□ Asthma	□ Anemia	□ Chronic lung condition
□ Blood clots	□ Drug and substance abuse	□ Depression/anxiety
□ Diabetes	□ Heart disease	□ High blood pressure
□ High cholesterol	□ Hepatitis/Jaundice	□ Cancer (Type)
□ Irritable bowel syndrome	□ Kidney stones	□ Hypothyroidism
□ Seizure disorder	□ Stroke	□ Tuberculosis
□ Stomach ulcers	□ Mitral valve prolapse	□ Rheumatic fever
□ Transfusion reaction	□ Eating disorder	□ Lupus/autoimmune

List all medications that you take with the dose and timing (including birth control pills): □ None

Drug	**Dose**	**Frequency**	**Reason for medication**

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: □ None
_____
_____

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Allergies: List all adverse reactions or allergies you have to medications and what happened.
□ None

_____

III. Surgical History □ None

List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, LEEP.

Date **Operation** **Diagnosis**

_____

_____

IV. General Health

How much alcohol do you drink/week? □ None □ Avg. less than 1/day □ Avg. 1/day □Avg. more

Do you smoke? □ Yes □ No Amount/day _____ How many years_____

If you quit smoking, when did you stop? _____

Have you used marijuana or other drugs in the last 5 years? □ Yes □ No Type: _____

Do you perform self breast examinations monthly? □ Yes □ No

V. Gynecologic History

Date of last pap smear: □ None _____
Date/place of last mammogram: □ None_____
Are you currently pregnant? □ Yes □ No □ Maybe
When was the FIRST day of your last menstrual period? _____ □ Menopausal □ Hysterectomy
Length of cycle from first day to first day each month: _____ days □ Regular □ Irregular
Average length of each period: _____ □ Heavy □ Moderate □ Light
What do you use to keep from getting pregnant? □ Nothing □ Vasectomy □ Condoms □ Rhythm □Tubal ligation □ IUD □ Diaphragm □ Birth Control Pills/Patch □ Abstinence □ Withdrawal

Please check if you have or have had any of the following:

□ Menstrual Cramps	□ PMS	□Recent change in periods
□ Endometriosis	□ Fibroids	□Laser/Freezing of Cervix
□ Ovarian cysts	□ Pelvic adhesions	□Herpes
□ Gonorrhea	□ Syphilis	□Chlamydia
□ Condyloma (warts)	□ Abnormal pap smear	□Recurrent vaginitis
□ Mycoplasma/Ureoplasma	□ Trichomonas	□HPV

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STD Screening: Would you like to have testing today? Please check any of the following test(s) that you are interested in having performed today:

□ **Chlamydia & Gonorrhea Screening** □ **HIV Testing**

□ **Herpes Screen** □ **Syphilis Screen**

Pregnancy history: □ No pregnancies
Number of times pregnant: ___ Full term births:___ Premature births:___ Elective termination:_____
Miscarriages _____ Ectopic pregnancies _____ Adopted children _____ Step children _____Twins _____

Pregnancies lasting more than 20 weeks:

Date	Length of preg. in weeks	Vaginal or C-section	Sex and weight	Hospital/Doctor	Complications

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