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
□ Asthma
□ Blood clots
□ Diabetes
□ High cholesterol
□ Irritable bowel syndrome
□ Seizure disorder
□ Stomach ulcers
□ Transfusion reaction
□ Anesthetic reaction
□ Anemia
□ Drug and substance abuse
□ Heart disease
□ Hepatitis/Jaundice
□ Kidney stones
□ Stroke
□ Mitral valve prolapse
□ Eating disorder
□ Bleeding disorder
□ Chronic lung condition
□ Depression/anxiety
□ High blood pressure
□ Cancer (Type)
□ Hypothyroidism
□ Tuberculosis
□ Rheumatic fever
□ 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
□ Endometriosis
□ Ovarian cysts
□ Gonorrhea
□ Condyloma (warts)
□ Mycoplasma/Ureoplasma
□ PMS
□ Fibroids
□ Pelvic adhesions
□ Syphilis
□ Abnormal pap smear
□ Trichomonas
□Recent change in periods
□Laser/Freezing of Cervix
□Herpes
□Chlamydia
□Recurrent vaginitis
□HPV

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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