URMC MIDWIFERY GROUP NEW PATIENT HISTORY

Please fill out this form and ***BRING TO YOUR APPOINTMENT****.*
If you are uncomfortable answering any question, leave it blank.

Name: ____ Date: ____________________

Prefer to be called: ___________________________________ Insurance: ________________

Address: ____

Telephone: (H) _____________ (W) _____________ (Cell) _____________OK to leave messages?___

Occupation / Employer: ____

Type of education or training: ________________ Highest grade completed: __________________

Single / Married / Separated / Divorced / Widowed Primary emotional supports: ________________

Partner's name: ___________________ Partner's age: _____ Partners' occupation: ______________

Religious preference: ____

Any religious objections to any form of medical treatment (eg, refusal of blood transfusion)? Yes No

Who may we thank for referring you to our practice? ______________________________________

What is the reason for today's visit? ____

If you are having a problem, please describe it: ____

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Allergies to any medications? ____

List all medications, vitamins or herbs you are taking ______________________________________

Nutrition:

Describe your diet: Well-balanced Fast food Vegetarian Vegan Kosher Gluten-Free
Describe your appetite: Good Fair Poor
How do you feel about your current weight? ______________________________________
Have you tried to gain or lose weight in the past? Yes No **Have you ever had an eating disorder?** Yes No
Do you have any food allergies or intolerance to foods? ______________________________________
How many times a week do you eat packaged food? (Example: Ramen noodles) ____________________
Do you ever eat things that are not food (ie, clay, starch, ice, plaster, paint)? Yes No

Habits and Activities:

What type of exercise do you do and how often? ______________________________________
Hours worked per day?____________ **Do you sleep well?** Yes No **How many hours per night?** _________
Ever smoked cigarettes? Yes No **Currently smoking?** Yes No **How much?** ______________
Alcohol: Drinks per week ____________ **Type?** ______________________________________
Recreational drugs? Yes No **Which ones?** ______________________________________
Does your partner or other family members abuse drugs or alcohol? Yes No **If so, who?** ______________
Do you do breast self-exams? Yes No **Do you wear seat belts?** Yes No
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Housing and Transportation:

Where do you live? Apartment Rented house Own home Stay with family or friends
Who lives in your household? _____
Have you moved more than 3 times in the last year? Yes No
Do you have adequate food storage/equipment (ie: refrigerator, stove) _____
What is you transportation? Car Bus Cab Other _____

Gynecologic History:

Age of first period _____How often do they come? _____ How long do they last? _____
Circle all that you have: PMS cramps heavy bleeding
Sexually active? Yes No Age of first intercourse? _____ Number of lifetime partners? _____
Partners? Men Women Both
Have you ever been: sexually abused? Yes No raped? Yes No

Current or most recent birth control method, if any _____
Circle all methods used in the past: Pills IUD Patch Ring Condoms Norplant Foam Diaphragm

Circle any you have had: Vaginal infections Pelvic infection STD's Herpes Genital warts
Abnormal pap smears Colposcopy Treatment of Cervix Breast lumps
Last mammogram,if applicable? _____

Who are Your Health Professionals ?

Primary Care Doctor _____ **Address:**_____
Dentist _____ **Last dental visit?** _____
Mental Health / Counselor _____
Chiropractor_____
Alternative Care Provider (Accupuncturist, Nutritionist)_____
Doula_____
Social worker/ Case Manager (including DSS) _____
Child Protective/Preventive Worker _____
Community Health Nurse or Outreach worker_____

Safety and Lead Screen

Are you remodeling and removing old paint, walls, or ceilings from housing built before 1960?	**Yes**	**No**
Does your house contain lead pipes or does the water contain lead?	**Yes**	**No**
Do you or others in your household have an occupation or hobby that involves working with lead?	**Yes**	**No**
Do you use home remedies or cosmetics that are homemade containing lead?	**Yes**	**No**
Do you feel afraid or unsafe where you live?	**Yes**	**No**
Are there guns in the household?	**Yes**	**No**
Have you ever been abused, hurt or threatened by anyone, including your parents?	**Yes**	**No**
Does your partner ever prevent you from going where you want, when you want?	**Yes**	**No**
Has your partner ever called you names or put you down?	**Yes**	**No**
Are you afraid of your partner?	**Yes**	**No**
Has your partner ever threatened to hit you or throw things at you?	**Yes**	**No**
Has your partner ever hit, slapped, kicked, punched, or threatened you with a weapon?	**Yes**	**No**
Have you ever had to see a doctor after your partner hit you?	**Yes**	**No**
Do you know who you can turn to if your partner was hurting you?	**Yes**	**No**

List All Hospitalizations (other than childbirth) and Surgeries

Year	Surgery or other Reason for Hospitalization	Hospital

Pregnancy History: (Include miscarriages and abortions)

Birth date	Place	Type of delivery	Weeks pregnant	Baby's sex and weight	Name and health now	Complications of pregnancy or birth
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

History of Illnesses for Myself and My Family

Illnesses	Myself	Family	Details
Urinary tract or bladder infections			
Kidney disease or stones			
High blood pressure			
Toxemia or pre-eclampsia			
Heart attacks or problems			
High cholesterol			
Rheumatic fever			
Varicose veins			
Blood clots in legs or lungs			
Stroke			
Sickle cell trait			
Anemia or low iron			
Bleeding problems			
Transfusions			
Asthma			
Environmental allergies			
Pneumonia or lung disease			
Tuberculosis			
Thyroid disease			
Seizures			
Headaches or migraines			
Depression			
Anxiety or panic attacks			
Drinking/drug problems			
Alzheimer's Disease			
Learning disabilities			
Mental retardation			
Birth defects			
Arthritis/back problems			
Broken bones			
Osteoporosis			
Problems with anesthesia			
Cancer			
Diabetes			
Bowel problems			
Gallbladder problems			
Lupus/ autoimmune disease			
Eye problems			
Hearing problems			
Chicken pox			
HIV/AIDS			
Hepatitis/Mono			

Please circle any problems with which you need help:

Financial **Transportation** **Parking** **Insurance** **Housing**

WIC/Food **Education** **Relationship issues** **Parenting**

Rev 1/11

(S\: Forms: New Patient History Form (Rev 1/11)