

**Weill Cornell Medical College**  
**Department of Obstetrics and Gynecology**  
**Division of Maternal Fetal Medicine**

- Dr. Grunebaum
- Dr. Kalish
- Dr. Lee
- Dr. Gelber

**New Patient Intake Form**  
 Answer all questions as they apply to you.  
 This form will be added to your medical record

- Dr. Sharma
- Dr. Genç
- Dr. Zervoudakis
- Dr. Pri-Paz

Who referred you? \_\_\_\_\_ Primary Care Provider \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of visit: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**Menstrual History:**

Date of last menstrual period: \_\_\_\_\_ Age (yrs) at 1st period \_\_\_\_\_ Age at Menopause \_\_\_\_\_

My period usually occurs every \_\_\_\_\_ days and lasts for \_\_\_\_\_ days. Heavy periods? \_\_\_\_\_ No \_\_\_ Yes \_\_\_\_\_

Painful periods? No \_\_\_ Yes \_\_\_\_\_ Irregular Bleeding? No \_\_\_ Yes \_\_\_\_\_ PMS (bloating, moody) No \_\_\_ Yes \_\_\_\_\_

**Genetic History**

Ethnic Background \_\_\_\_\_ Partner's Age & Ethnic Background: \_\_\_\_\_

**Has anyone in your family or your partner's family had any of the following: (Who?)**

Autism _____	Mental Retardation _____
Birth Defect _____	Muscular Dystrophy _____
Congenital Heart Disease _____	Open Spine (Bifida) _____
Cystic Fibrosis _____	Sickle Cell Anemia _____
Down's Syndrome _____	Thalassemia _____
Hemophilia _____	Unexplained Fetal Loss _____
Huntington's Disease _____	Other _____

**Gynecologic History**

Last Pap smear? \_\_\_\_\_ Abnormal Pap smears? No \_\_\_ Yes \_\_\_ (Year and treatment given) \_\_\_\_\_

Last Mammogram? \_\_\_\_\_ Abnormal Mammograms? No \_\_\_ Yes \_\_\_ (Year and treatment given) \_\_\_\_\_

**Have you ever had any of the following infections? If so, when and how was it treated?**

Gonorrhea \_\_\_\_\_ Chlamydia \_\_\_\_\_ Herpes \_\_\_\_\_ Trichomonas \_\_\_\_\_ Genital Warts or HPV \_\_\_\_\_ Syphilis \_\_\_\_\_ None \_\_\_\_\_

**Have you had any of the following conditions? If yes, please detail year and treatment below:**

Uterine fibroids \_\_\_\_\_ Infertility \_\_\_\_\_ Ovarian Cysts \_\_\_\_\_ Breast disease/biopsy \_\_\_\_\_ Endometriosis \_\_\_\_\_ None \_\_\_\_\_

**Contraception/Pregnancy History**

Are you sexually active? \_\_\_\_\_ Any problems? \_\_\_\_\_

Your current method of preventing pregnancy is: \_\_\_\_\_

Total number of pregnancies \_\_\_\_\_ Vaginal deliveries \_\_\_\_\_ C-Section \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Ectopic \_\_\_\_\_

Pregnancy Complications \_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTION:**

**Would you accept a blood transfusion in a life threatening situation? NO \_\_\_ YES \_\_\_**

**Pregnancy History**

Date	Delivery Type	Birth Weight	Gender/Name	Complication

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\*\*\*ALLERGIES: No \_\_\_\_\_ Yes: \_\_\_\_\_

**Medications: (List names and dosages; include vitamins, herbs and other supplements):**

Name of Medication	Dosage	How Often	Name of Medication	Dosage	How Often

**Medical History (Either now or in the past. Detail below with year of diagnosis and treatment given)**

<input type="checkbox"/> Anemia (Blood Transfusion?)	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Neurologic Disorder
<input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Seizure Disorder/Epilepsy
<input type="checkbox"/> Congenital Heart Problem	<input type="checkbox"/> Lung Disease/Asthma	<input type="checkbox"/> Sickle Cell/Carrier
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lupus	<input type="checkbox"/> TB/Positive PPD
<input type="checkbox"/> Gastrointestinal/Gallstones	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thrombotic Disorder (Blood Clots)

**Surgical History**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History**

Mother: Living \_\_\_\_\_ Deceased (cause) \_\_\_\_\_ Father: Living \_\_\_\_\_ Deceased (cause) \_\_\_\_\_  
Siblings: Number Living \_\_\_\_\_ Number deceased \_\_\_\_\_ Cause \_\_\_\_\_

**Detail below if anyone in your immediate family had the diagnosis: (Indicate, Mother Father, Sibling, grandparents (which side))**

<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer-Other	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Neurological Disease	Other: _____
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Psychiatric disease	Other: _____
<input type="checkbox"/> Cancer: Breast/GYN	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Pregnancy	<input type="checkbox"/> Thyroid Disease	Other: _____

**Social History**

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How many packs a day? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_ Any other drugs? \_\_\_\_\_ Which ones? \_\_\_\_\_

**Review of Systems: Are you experiencing any of the following symptoms? Please indicate all that apply or NO if they do not.**

<b>Constitutional</b>	<input type="checkbox"/> No	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fever	<b>Other</b>
<b>Eye Problems</b>	<input type="checkbox"/> No	<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Glasses/Contacts			
<b>Ear, Nose, Throat</b>	<input type="checkbox"/> No	<input type="checkbox"/> Headache	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Ringing In Ears	<input type="checkbox"/> Nose Bleed	
<b>Cardiovascular</b>	<input type="checkbox"/> No	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Edema	<input type="checkbox"/> Palpitations	
<b>Respiratory</b>	<input type="checkbox"/> No	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Cough		
<b>Gastrointestinal</b>	<input type="checkbox"/> No	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody Stool	
<b>Genitourinary</b>	<input type="checkbox"/> No	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequency	
<b>Musculoskeletal</b>	<input type="checkbox"/> No	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Muscle Pain			
<b>Skin/Breast</b>	<input type="checkbox"/> No	<input type="checkbox"/> Breast Pain	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Breast Mass	<input type="checkbox"/> Skin Rash	
<b>Neurological</b>	<input type="checkbox"/> No	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness	<input type="checkbox"/> Trouble Walking	
<b>Psychiatric</b>	<input type="checkbox"/> No	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety			
<b>Endocrine</b>	<input type="checkbox"/> No	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Abnormal Thirst	<input type="checkbox"/> Hot Flashes		
<b>Blood/Lymph</b>	<input type="checkbox"/> No	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Swollen Glands		

Reviewed By: \_\_\_\_\_, MD on \_\_\_\_\_ (Date)