Paul Wexler, M.D./GENASSIST™, Inc. (Revised 5/23/18)

(New Patient Medical Form)

Patient Name:_________________________ **Date of Birth**__________
Referred By:_______________________________________
Home Address____
Phone (h)______________ Phone (b)______________ Phone (Cell)____________
Email__________________________________

Why are you here today?____
____
Patient Height__________ Patient Weight _________

Do you have any allergies/problems with medications? YES NO
If yes, please list____
Are you currently taking any medications? YES NO
If yes, please list____
____

Do you use birth control? YES NO If yes, what type?_______________________
What was the first day of your last menstrual period?______________
When was your last pap smear?__________ Was it normal? YES NO
Have you ever had a mammogram? YES NO If yes, when?___________
History of Present Illness____
____

FAMILY HISTORY:

Is your mother alive? YES NO If yes, her age & general health?________________
If no, cause and age at death?____
Is your father alive? YES NO If yes, his age & general health?________________
If no, cause and age at death?____
Do you have brothers? YES NO If yes, their ages and general health____________
____
Do you have sisters? YES NO If yes, their ages and general health____________
____

HAVE ANY OF THE WOMEN IN YOUR FAMILY HAD?:

Breast cancer: YES NO If yes, who?________________________________
Cancer of the Ovary: YES NO If yes, who?____________________________
Cancer of the Uterus: YES NO If yes, who?___________________________
Cancer of the Cervix: YES NO If yes, who?___________________________
Other significant illnesses in your family________________________________
____
____

MENSTRUAL & PREGNANCY HISTORY

Are you still having periods? YES NO If no, your age at least period?_______________
Are your periods usually regular? YES NO
How many days between 1st day of period and 1st day of the next period?__________
How many days do you bleed?________ Are your periods painful? YES NO
Have you ever been pregnant? YES NO If yes, how many times?___________
Do you have any living children? YES NO If yes, how many?__________
Have you had any miscarriages? YES NO If yes, how many?__________
Have you had any stillbirths? YES NO If yes, how many?__________
Have you had any elective terminations of pregnancy? YES NO If yes, how many?__________
Have you had any complications in pregnancy or delivery? YES NO If yes, please explain____

PERSONAL HISTORY:

Surgical history (list operations and dates):_______________________________________
____
____

HAVE YOU EVER HAD THE FOLLOWING:

Inflammation of the veins (phlebitis):	YES NO
Migraine headaches:	YES NO
Gonorrhea/syphilis/Chlamydia: (circle those that apply)	YES NO
Herpes:	YES NO
AIDS:	YES NO
Hepatitis A, B or C:	YES NO
Warts on the Genitals:	YES NO
Abnormal Pap Smears:	YES NO
Uterine Infection:	YES NO

Do you smoke? YES NO If yes, how many packs per day?________
Do you drink alcohol? YES NO If yes, how many per day (please circle)
1 drink or less/week Less than 1 drink/day
1-2 drinks/day More than 2 drinks/day

Other history that you want us to be aware of____
____
____
____
Comments____
____