BMH MEDICAL GROUP
a Department of Brattleboro Memorial Hospital

FOUR SEASONS OB/GYN & MIDWIFERY
NEW PATIENT HEALTH HISTORY FORM

Last Name: **First Name:** **Middle Initial:**

Date of Birth: **Gender Identity:** **Preferred Name:**

Insurance Name & Gender (if different than above): □ n/a

Photo ID Name & Gender (if different than above): □ n/a

Birth Certificate Name & Gender (if different than above): □ n/a

Relationship status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐Other

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other (Please list):

Members of Household (Relationships and Ages):

Occupation: **Highest Level of education completed:**

Is English your primary language? ☐ Yes ☐ No If no, what is?

Primary Care Provider: **Practice Name:**

Preferred Pharmacy:

Reason for your visit:

MEDICAL ISSUES

Mark the 'C' box for CURRENT conditions and 'P' for PAST conditions

C	P	***Cardiovascular***	C	P	***Cancer***	C	P	***Gyn/Urinary***
□	□	High blood pressure	□	□	Breast cancer	□	□	Endometriosis
□	□	High cholesterol	□	□	Uterine/endometrial	□	□	Fibroids
□	□	Heart disease (CAD/MI)	□	□	Thyroid	□	□	Uterine polyps
□	□	Deep vein thrombosis	□	□	Other:	□	□	PCOS
□	□	Pulmonary embolism			***Digestive/GI***	□	□	Frequent UTIs
□	□	Anemia	□	□	Reflux/GERD	□	□	Kidney stones
		Endocrine	□	□	Crohn's/ulcerative colitis	□	□	Kidney infection
□	□	*Hypo*thyroidism (low)	□	□	Liver disease/Hepatitis	□	□	Other:
□	□	*Hyper*thyroidism (high)	□	□	Irritable bowel syndrome			***Psychological***
□	□	Diabetes □ Type 1 □ Type 2	□	□	Gallbladder disease	□	□	Depression
		Musculoskeletal	□	□	Liver disease/Hepatitis	□	□	Anxiety
□	□	Arthritis	□	□	Ulcers	□	□	Postpartum depression
□	□	Osteoporosis	□	□	Gallbladder disease	□	□	PMS or PMDD
		Respiratory			***Neurological***	□	□	ADHD
□	□	Asthma	□	□	Migraines (aura? □ yes □ no)	□	□	Alcoholism
□	□	COPD	□	□	Epilepsy	□	□	Eating disorder
			□	□	Multiple sclerosis	□	□	Substance use disorder

Others:_____

_____

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

Medication Name	Dosage	Doses/day	Reason you take this medication	Refill needed?

My signature acknowledges my understanding that the medical providers of BMH Medical Group are not obligated to prescribe any medications or any dosages of medications that they feel are not in my best interest.

Signature **Date**

MEDICAL ALLERGIES

Include medications, latex, iodine

Allergen Name	What type of allergic reaction do you have?

HEALTH SCREENING

	Last date completed	Outcome of screening				
General Physical		□ never	□ normal	□ abnormal (specify):		
Mammogram		□ never	□ normal	□ abnormal (specify):		
Colonoscopy		□ never	□ normal	□ abnormal (specify):		
Bone Density		□ never	□ normal	□ abnormal (specify):		
Covid Vaccination(s)		□ never	□ 1 dose	□ 2 doses	□ 3 doses	□ 4 or more doses

SOCIAL HISTORY

Alcohol	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
Tobacco/Vaping	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
Recreational Drugs *Type(s):*_____ _____	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never
Exercise *Type(s):*_____ _____	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly	☐ Never

FAMILY HEALTH HISTORY

List parents, siblings, children, grandparents, aunts, and uncles

Breast Ovarian, Uterine, or Colon Cancers ☐ None ☐ Yes:	
Other Cancers	
Diabetes	
Thyroid Disorder	
Heart Disease	
High Blood Pressure	
Mental Health	
Substance Use	
Hip Fracture	
Pulmonary embolism or deep vein thrombosis	
Other	

SURGICAL HISTORY

Please list all operations, including c-sections and gyn procedures (LEEPs, D+Cs, hysteroscopy, hysterectomy)

DATE	HOSPITAL	SURGERY

OBSTETRIC HISTORY

List Total Number of:

All pregnancies ________ Births _________ Miscarriages _______ Abortions ________ Ectopic pregnancies_______

BIRTHS

DATE	HOSPITAL	WEEKS	WEIGHT	SEX	OUTCOME (circle one)	COMPLICATIONS/COMMENTS ABOUT PREGNANCY OR DELIVERY
e.g: 1988	***BMH***	***37***	***8lb, 2 oz***	***F***	vaginal c-section	***(i.e. shoulder dystocia, gestational diabetes, preeclampsia)***
					vaginal c-section	
					vaginal c-section	
					vaginal c-section	
					vaginal c-section	
					vaginal c-section	
					vaginal c-section	

OTHERS

DATE	WEEKS	TYPE (check type and circle details)		
		□ **Miscarriage** (D&C Yes/No)	□ **Abortion** (D&C or Pills)	□ **Ectopic** (treatment: meds or surgery)
		□ **Miscarriage** (D&C Yes/No)	□ **Abortion** (D&C or Pills)	□ **Ectopic** (treatment: meds or surgery)
		□ **Miscarriage** (D&C Yes/No)	□ **Abortion** (D&C or Pills)	□ **Ectopic** (treatment: meds or surgery)
		□ **Miscarriage** (D&C Yes/No)	□ **Abortion** (D&C or Pills)	□ **Ectopic** (treatment: meds or surgery)
		□ **Miscarriage** (D&C Yes/No)	□ **Abortion** (D&C or Pills)	□ **Ectopic** (treatment: meds or surgery)
		□ **Miscarriage** (D&C Yes/No)	□ **Abortion** (D&C or Pills)	□ **Ectopic** (treatment: meds or surgery)

GYNECOLOGIC HISTORY

Are you sexually active? □ Yes □ No □ Never

Number of partners in the past 12 months? 5 or more lifetime sexual partners? □ Yes □ No

Sexual orientation: □ Straight □ Lesbian or Gay □ Bisexual □ Asexual □ Pansexual □ Fluid □ Questioning □ Prefer not to say □ Other

Cervical Cancer Screening (pap smears)

Last pap smear (date/location): Result:

Have you ever had an abnormal pap? □ yes □ no □ unsure If yes, where: when:

Have you ever had a pap with HPV? □ yes □ no □ unsure If yes, where: when:

HPV Vaccination (Gardasil): □ completed series □ started series, not complete (total injections:) □ never □ unsure

Abnormal Paps (if applicable)

Have you had a colposcopy? □ yes □ no □ unsure If yes, where: when:

Have you had a LEEP, cold knife cone, or cervical cryosurgery? □ yes □ no □ unsure If yes, where: when:

Pelvic Imaging (within the last 5 years)

Pelvic Ultrasound □ yes □ no □ unsure If yes, where: when:

Pelvic or Abdominal MRI □ yes □ no □ unsure If yes, where: when:

Pelvic or Abdominal CT □ yes □ no □ unsure If yes, where: when:

Sexually transmitted infections (circle any that you have been diagnosed with)

Chlamydia	Gonorrhea	Trichomoniasis
Genital Herpes	Pelvic Inflammatory Disease	Syphilis
HIV	Genital warts	Other

Current gynecologic problems or concerns, not addressed elsewhere

- □ Difficulty with pelvic exams
- □ Concerns about STIs or want screening
- □ Vaginal odor or unusual discharge
- □ Abnormal uterine or vaginal bleeding (including heavy bleeding, irregular bleeding, bleeding after sex or between periods)
- □ Pain with intercourse
- □ Pelvic pain or pressure
- □ Vulvar itching, irritation, or lesions
- □ Recurrent vaginitis
- □ Difficulty getting pregnant or need for assisted reproductive technology (insemination, etc.)
- □ Other:

Safety Concerns

Have you ever experienced any sexual abuse or assault? □ Yes □ No

Do you have any concerns about your safety? □ Yes □ No

If yes:

Have you talked with someone about this? □ Yes □ No

Do you want to speak with someone about this? □ Yes □ No

Specific topics you would like to discuss at your visit

GYN HISTORY (MENOPAUSAL PATIENTS ONLY)

Age of menopause:

Have you taken hormone therapy? □ Never □ Yes, currently (since year:) □ Yes, past (# of years)

Have you used topical hormones? □ Never □ Yes, currently (type:) □ Yes, past type:)

Do you have any of the following menopausal symptoms/issues:

- □ Postmenopausal bleeding
- □ Hot flashes
- □ Vaginal dryness and/or pain with intercourse
- □ Mood changes
- □ Brain fog
- □ Insomnia
- □ Incontinence (circle one: urinary, bowel, both)
- □ Pelvic organ prolapse

GYN HISTORY (PREMENOPAUSAL PATIENTS ONLY)

Age of first period: Date of last menstrual period (day period started):

Do you menstruate? □ Yes □ No

If NO, why? □ Hysterectomy (age/year): □ Other reason:

Frequency of menses:

- □ Regular/ monthly (every _____days, last for _____days)
- □ Irregular: explain:

Bleeding between periods? □ Yes □ No

How heavy are your periods?

- □ Normal, not heavy
- □ Moderately heavy but not concerning # of pads/tampons/cups on the heaviest day:
- □ Very heavy and concerning # of pads/tampons/cups on the heaviest day:

How painful are your periods?

- □ None □ Mild pain, over the counter meds work
- □ Moderate □ Severe pain, prescription meds, miss work/school

Contraception

If you are not at risk for pregnancy due to abstinence, hysterectomy, or same-sex sexual activity check here and skip section □

Please mark the "C" for current and "P' for past.

C	P		C	P	
□	□	None (you do nothing to prevent pregnancy)	□	□	Birth Control Pills
□	□	Patch	□	□	NuvaRing
□	□	Cooper/Paragard IUD (insert date)	□	□	Withdrawal
□	□	Hormonal IUD (insert date _____) *Type*: Mirena Liletta Kyleena Skyla	□	□	Tubal Sterilization *Type:*
□	□	Nexplanon/Implant	□	□	Vasectomy:
□	□	Condoms	□	□	Rhythm/ Natural Family Planning
□	□	Depo-Provera	□	□	Diaphragm

Are you interested in changing/starting a new contraceptive method? □ Yes □ No

REVIEW OF SYSTEMS:

Please check all that currently apply

General/Constitutional:					
□	Fatigue	□	Fever	□	Chills
□	Unexplained weight loss	□	Unexplained weight gain		
Eyes:					
□	Floaters	□	Peripheral vision changes	□	Blurred vision
Head/ Throat:					
□	Ringing in the ears	□	Migraine	□	Headache
□	Vertigo/dizziness	□	Lightheadedness		
Breast:					
□	Tenderness	□	Lumps	□	Skin Changes
□	Nipple Pain	□	Nipple Discharge		
Cardiovascular:					
□	Chest pain	□	Leg swelling	□	Palpitations
Respiratory:					
□	Pain with breathing	□	Shortness of breath/ wheezing	□	Cough
Gastrointestinal:					
□	Reflux/heartburn	□	Bloating	□	Bowel leakage/ incontinence
□	Nausea/Vomiting	□	Constipation	□	Diarrhea
Urinary:					
□	Leaking urine	□	Urinary frequency	□	Urinary urgency
□	Painful urination	□	Blood in urine		
Skin:					
□	Rash	□	New skin lesion	□	Acne
□	Excessive hair growth				
Neurologic:					
□	Weakness of arms or legs	□	Tingling or numbness	□	Memory difficulties
Musculoskeletal:					
□	Joint pain	□	Muscle weakness	□	
Endocrine:					
□	Excessive thirst	□	Excessive urination	□	Loss of hair
□	Cold intolerance	□	Heat intolerance		
Psychiatric:					
□	Marital stress	□	Family Stress	□	Job Stress
□	Depression	□	Frequent Crying	□	Excess anger/irritability
□	Difficulty sleeping	□	Anxiety	□	PTSD
Hematologic/Lymphatic:					
□	Lymph node enlargement	□	Easy bruising	□	Easy bleeding
Allergic/ Immunologic:					
□	Sinus allergy	□	Allergic Dermatitis		

I acknowledge that I have completed this form to the best of my ability. I realize that any information that I provide on this form will become part of my permanent medical record. I understand that any misrepresentations of my health history may result in an alteration of my current treatment plan, as deemed appropriate by my BMH Medical Group healthcare provider.

Signature: **Date:**

Name (print): **Relationship to Patient:**

Power of Attorney ☐ **Yes** ☐ **No**

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