

PERLIS WELLNESS CENTER

81 E. Scranton Ave
Lake Bluff, IL 60044
847-295-5997

NEW PATIENT HISTORY

Name: _____ Date: _____

Age: ____ Occupation: _____ Marital Status: S ____ M ____ D ____ W ____

How did you hear about us: _____

Reason for making appointment today: _____

HISTORY

List all surgeries, accidents and hospitalizations that you have had:

Year	Nature of illness, injury or surgery	Hospital Name

List all medications, vitamins, diet supplements and herbal preparations that are you taking:

1		5	
2		6	
3		7	
4		8	

List all drug, latex, food or environmental allergies that you have:

1		5	
2		6	
3		7	
4		8	

Pregnancy and Childbirth History:

Year	Type of Delivery	Birth weight	Complications

Have you ever had a miscarriage? No__ Yes, how many?_____

Have you ever had an abortion? No__ Yes, how many?_____

Have you ever had an ectopic pregnancy? No__ Yes, how many?____

Do you have any adopted children? No__ Yes, how many?_____

Menstrual, contraceptive and gynecologic history:

Date started last period? _____ Date of last Pap smear? _____

Have you ever had an abnormal pap smear? Y or N, if Yes what type abnormality_____

Treatment required_____

How old were you when your periods started? _____

How often do you get your periods? Every _____ days

How long do your periods last? ____ to ____ days

Do you have painful periods or cramps?_____

Do you have history of ovarian cysts_____ endometriosis_____ uterine fibroids_____

Have you ever been sexually active? Y or N with males / females / both

Do you have pain with sex? Y or N

What method are you using (if any) to prevent pregnancy? _____

Did you want testing for sexually transmitted diseases? Y or N

How many sexual partners:in the past year_____ lifetime_____

Have you ever had (circle appropriate answer) gonorrhea/chlamydia/herpes/syphilis/
trichomonas/HIV/AIDS/genital warts/hepatitis B/hepatitis C?

Have you ever had difficulty getting pregnant? Y or N

What have you tried to do to get pregnant? Clomid /IUI /IVF _____

Have you ever had intercourse against your will? Y or N

Have you previously or currently been abused by your partner? Y or N

Social History:

Do you/did you ever smoke? Y or N

How much do you/did you smoke? _____ How long?_____

How much alcohol do you drink (per day/week/month)? _____

What illegal drugs do you use (how often and how much)? _____

Has your weight changed over the past year? _____

Do you exercise regularly (what kind and how much)? _____

Additional Personal and Family History:

Illness	Yourself	Family Member (specify who and what)
Neurological (migraines, seizure, etc)		
Diabetes		
High blood pressure, stroke		
Heart disease, mitral valve prolapse		
Cancer (colon, ovarian, breast, uterine, etc)		
Endocrine (thyroid disorder, etc)		
Respiratory (asthma, emphysema, etc)		
Intestinal (reflux, IBS, ulcers, etc)		
Arthritis		
Kidney (stones, dialysis, etc)		
Mental health (depression, anxiety, bipolar, etc)		
Liver (jaundice, hepatitis, etc)		
Autoimmune disorders (lupus, fibromyalgia, etc)		

Reviewed by: _____ (health professional) Date: _____