

**New Patient Form**  
**Meenakshi Jain M.D., FACOG**

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Name: \_\_\_\_\_

Chief Complaints:

Menstrual History:

Contraceptive History: \_\_\_\_\_ PID: \_\_\_\_\_

Sex History:

Urinary / Bowel:

Mammogram: Yes / No \_\_\_\_\_ Date: \_\_\_\_\_ Last Pap Smear: \_\_\_\_\_

Medical History:

- |   |                        |   |
|---|------------------------|---|
| 1. Jaundice, hepatitis, or other liver disorders: _____ | Patient ___ Family ___ | 10. Headaches or a nervous disorder:.....     |
| 2. Cancer:.....   | Patient ___ Family ___ | 11. A lung disorder:.....                     |
| 3. Diabetes:.....                                       | Patient ___ Family ___ | 12. Anemia or blood disorder:.....            |
| 4. Breast problems.....                                 | Patient ___ Family ___ | 13. A heart condition or high blood pressure: |
| 5. Birth defects or inherited diseases.....             | Patient ___ Family ___ | 14. Kidney or bladder problems.....           |
| 6. Other medical problems.....                          | Patient ___ Family ___ | 15. A thyroid problem:.....                   |
| 7. A blood transfusion.....                             | Patient ___ Family ___ | 16. Stomach, bowel or gallbladder problems:   |
| 8. Ovarian Cancer:.....                                 | Patient ___ Family ___ | 17. Breast Cancer:.....                       |
| 9. Uterine Cancer:.....                                 | Patient ___ Family ___ | 18. Colon Cancer:.....                        |

Previous Hospitalizations/ Illness:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Personal History:

Smoke:

Alcohol:

Drugs:

Allergy:

Medications:

G  
P

STD:  
GC:  
Chlamydia:  
Herpes:  
HPV:  
Syphillis:

Date:

Patient\_\_\_Family\_\_\_  
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Date:

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Occupation: