The Whole Woman, PLLC
Amy M. Bruton, MD

New Patient Information Form

Name: _____ Age: _____ DOB: _____

Referring Physician:_____ Primary care physician:_____

Trying to conceive? No ☐ Yes ☐ If so how long?_____ (years and months)
Date last pap:_____ Result:_____ Date last mammogram:_____
Date last colonoscopy:_____ Result:_____ Recommended f/u:_____ (years)
Date last bone density:_____ Result:_____

Menstrual History: Age at first menses:_____ Date of last period:_____ Normal?_____
Usual days between menses:_____ How long are your periods:_____ How many days are heavy?____
On your heaviest day how many pads/tampons do you use?_____ Cramping? mild/moderate/severe
PMS? mild/moderate/severe Most bothersome symptoms:_____

Gynecological History: (circle response)

Abnormal pap	yes	no	Exposure to DES	yes	no
Acne	yes	no	Mycoplasma	yes	no
Breast discharge	yes	no	Ovarian cysts	yes	no
Chlamydia	yes	no	Painful intercourse	yes	no
Douche	yes	no	Pelvic adhesions	yes	no
Endometriosis	yes	no	Pelvic infection	yes	no
Anxiety	yes	no	Physical abuse	yes	no
Fibroids	yes	no	Previous IUD use	yes	no
Gonorrhea	yes	no	Sexual abuse	yes	no
Herpes	yes	no	Vaginal/vulvar pain	yes	no
Hot flashes	yes	no	Use of lubricants	yes	no
Leak of urine	yes	no	Urinary frequency	yes	no
Urinary urgency	yes	no	Pelvic pain/cramps	yes	no
Decreased libido	yes	no	Lack of arousal	yes	no
Lack of orgasm	yes	no	Breast lump	yes	no
Spotting	yes	no	Brown bleeding	yes	no

Social History:

Alcohol use: yes no type:_____ #/day:_____ #/week:_____
Caffeine use: yes no type:_____ #/day:_____ #/week:_____
Tobacco use: yes no type:_____ #/day:_____
Recreational drug use ever: yes no type:_____
Recreational drug use current: yes no type:_____ how often:_____
Regular excersize: yes no type:_____ days/week:_____
Occupation:_____

Marital status: M S W D (circle all that apply) Years together:_____
Partner's name:_____ Age:_____ Occupation:_____

Name: DOB: DOS:

General Symptoms: (circle if current problem)

Weight gain >10 lbs	Vision problems	Fatigue	Depression
Weight loss > 10 lbs	Diarrhea	Clumsiness	Food cravings
Nausea/Vomiting	Allergies	Constipation	Food intolerance
Bowel cramping	Acid reflux	Low sugar	Dry eyes
Memory problems	Brittle nails	Dry hair	Hair loss
Numbness hands/feet	Headache	Joint pain	Muscle pain/ache
Heat intolerance	Mouth sores	Tongue sores	Dry skin
Cold intolerance	Easy bruising	Insomnia	Cough/breathing problems
Blood in stool	Dizziness	Fainting	Easy bleeding
Intestinal cramping	Palpitations	Excessive thirst	Chest pain

Other:_____

Medical History:

Eyes:_____ Nose:_____
Ears:_____ Thyroid:_____
Neurolgic:_____ Heart:_____
Lungs:_____ Skin:_____
Gastrointestinal:_____ Blood:_____
Liver:_____ Kidney:_____
Bladder:_____ Mental:_____
Autoimmune:_____ Infections:_____
Cancer:_____ Diabetes (type and years):_____

Other:_____

Surgical History (include surgery, date, and where performed): _____

_____

_____

Family History (include chronic illness, cancer, genetic disorder, bleeding/clotting disorder, pregnancy/gyn problems, etc.):

Maternal grandmo.: _____ Maternal grandfa.:_____

Paternal grandmo.:_____ Paternal grandfa.:_____

Mother:_____ Father:_____

Sisters:_____

Brothers:_____

Children:_____

Aunts:_____

Uncles:_____

Name: DOB: DOS:

Ancestral Background: (certain illness and genetic disorders are more common in particular ancestral backgrounds):

- ☐ African
- ☐ French Canadian
- ☐ Latin American
- ☐ Ashkenazi Jewish
- ☐ Mediterranean
- ☐ Native American
- ☐ Caribbean
- ☐ Sephardic Jewish
- ☐ Asian
- ☐ Indian
- ☐ Other:_____

Pregnancy History: Total pregnancies:_____ Term births:_____ Preterm births:_____
Induced abortions:_____ Miscarriages:_____ Adopted children:_____

Complications:_____

Contraceptive Use (include type, when used, why discontinued):_____

_____

_____

Do you use natural family planning: yes no type:_____

Current Medications (include prescription, over-the-counter, vitamins, and supplements):

Medication	Dose/Frequency	Reason for using

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies (include medication and reaction):_____

_____

_____