NEW PATIENT INFORMATION

Date: ______________	Samreen Akbar (M.D.) FACOG Obstetrician & Gynecologist **UpToDate Healthcare for Women** 2500 W. Higgins Road, Suite 920 Hoffman Estates, IL 60169-2048 t: 847.466.7260, f: 847. 466.7747	

PATIENT's Name:	Weight	Lbs.	Height:	ft ', in "	DOB	MM	DD	YYYY

Personal & Family History	No	Yes	Gynecological History	No	Yes
Alcoholism	( )	( )	Infertility	( )	( )
Anemia	( )	( )	Abnoraml Pap	( )	( )
Asthma / Lung Problems	( )	( )	Treatment /When:		
Blood Clots	( )	( )	Chlamydia	( )	( )
Chickenpox	( )	( )	Gonorrhea	( )	( )
Colon/Rectal, blood in stool, diarrhea, constipation	( )	( )	Herpes	( )	( )
Diabetes	( )	( )	Syphillis	( )	( )
Heart Disease	( )	( )	HIV	( )	( )
High Blood Pressure	( )	( )	Condylomata (warts)	( )	( )
Kidney Disease	( )	( )			
Liver Disease	( )	( )	**Menstrual History**		
Loss of Urine	( )	( )			
Neurologic: Epilepsey/Chronic Headache	( )	( )	Age at onset		
Osteoporosis	( )	( )	Regular (R-Regular, NR-Not)	R	NR
Stroke	( )	( )	Cycle (days)		Days
Thyroid Disease	( )	( )	Duration (days)		Days
Other:			Flow: Light (L) Moderate (M) Heavy (H)		
			Pain or Cramps	No	Yes
			Date of LMP		

7 Question Family History Screening - 'CANCER' (first degree relatives: Parents/Siblings/Offspring)			Previous Pregnancy		
Did any of your relatives have breast or ovarian cancer?	( )	( )	Toxemia	( )	( )
Did any of your relatives have bilateral breast cancer?	( )	( )	Diabetes	( )	( )
Did any man in your family have breast cancer?	( )	( )	High Blood Pressure	( )	( )
Did any woman in your family have breast or ovarian cancer?	( )	( )	Preterm Labor /Birth	( )	( )
Did any woman in your family have breast cancer before age 50 Y?	( )	( )	Birth Defects	( )	( )
Do you have 2 or more relatives with breast and/or ovarian cancer?	( )	( )	Genetic Problems	( )	( )
Do you have 2 or more relatives with breast and/or bowel cancer?	( )	( )	Multiple Births	( )	( )
check if back of the form used		( )	check if back of the form used		( )

Last Mammogram Date:

Results:

Have you ever had an abnormal mammogram	No	Yes	If yes then, Month: __________, Year: ________

Details of Treatment / Procedure Performed (if yes.):

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Please List ALL Surgeries /Hospitalizations /Reasons (use back of the form if needed)	Month	Year
1)		
2)		
3)		

Allergies (use back of the form if needed):

Please List ALL Pregnancies (use back of the form if needed)

Mode of Delivery	Complications	Year	Weeks	Weight	Gender
1)					
2)					
3)					

Current Medications (use back of the Form if needed):

Pharmacy Address:

Phone #: ______________ City: ______________ IL, Zip: ______________

Patient Name: ______________

Signature: ______________

Date: ______________