Dr. Caitlin Schmidt D.O

Gynecologic New Patient Information

Patient Name *(First, MI, Last)* _____

Preferred Name *(e.g. "Bob" or "Pat")*_____

Mailing Address _____

Phone Number(s) _____ *(Home)* _____*(Cell)*

Date of Birth _____ **Social Security Number** _____

Email Address _____

Sex/preferred gender identity _____

Primary Language _____ **Translator Needed?** *(Yes or No)* _____

Race *(Circle One)* *American Indian or Alaska Native *Asian *Native Hawaiian *Other Race
*Black or African American *White *Hispanic *Other Pacific Islander

Ethnicity *(Circle One)* *Hispanic *Non-Hispanic

Employer _____

Employer Phone Number and Location *(City, State)* _____

Pharmacy Name/Location _____

Name of your primary care physician: _____

Medications & Dosages

(Please include supplements)

Medication	Dose	Frequency

Medical History

Please list all of your current and past medical diagnoses

Please list any allergies and the reaction: _____

_____

Gynecologic History

1. Sexual/Physical/Emotional abuse history: (if yes are you safe now?) _____
2. Specific gynecologic concerns? (Endometriosis/Fibroid/Infertility/PCOS/ Menopause)
   _____
   _____
   _____
   _____
3. Please circle if you have had any of the following cervical procedures:

LEEP Conization Cryotherapy TCA

4. Last Menstrual Period (date): _____
5. History of Sexually Transmitted infections: _____
6. Are you currently using birth control? _____
7. Is there any any information you would like to share regarding your gender identity?

   _____
8. Date of last pap smear and results if known; do you have a history of an abnormal pap smear:

   _____
9. Date of last mammogram and results if known: _____
10. Date of last bone density results if known: _____
11. Have you completed the Gardasil vaccine: _____

Obstetric/Pregnancy History

□ I have never been Pregnant

Pregnancies	Number
Vaginal deliveries	
c-section deliveries	
Induced abortion	
Spontaneous abortion (miscarriage)	
Ectopic pregnancy	
Fetal demise	

Surgical History

Date of Surgery	Surgeries Performed & Surgeon Name *(if known)*

Social History

Tobacco Use

Are you a : □ Current Smoker □ Former Smoker □ Never Smoked

If you were a former smoker, how many years did you smoke and when did you quit: _____

Alcohol Use:

Did you have a drink containing alcohol in the past year? □ Yes □ No

If Yes, how often did you drink in the past year? □ Once per month or less □ 2-4 times per month

□ 2-3 times per week □ 4+ times per week

If Yes, how many drinks did you have on a typical day when you were drinking in the past year?

□ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10+

If yes, how often did you have 6 or more drinks on one occasion in the past year?

□ Never □ Less than once per month □ Monthly □ Weekly □ Daily or almost daily

Do you use recreational drugs:_____

How many days per week do you exercise:_____

Marital Status_____ **Spouse's Name** *(If applicable)*_____

Do you have children? If so, names/ages_____

Occupation/Employer _____

Are you sexually active? _____

Have you had a hospitalization in the past year: _____

Family History

Family Member	**Status** (*Living or Deceased)*	**Age** *(Current age if alive)*	**Serious Health Conditions**
Father			
Mother			
Brother(s)			
Sister(s)			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Other concerns for hereditary illness:_____

Do you currently leave the Traverse City area for the winter months *(Yes or No)**?*** _____

If yes, what is the approximate month of your departure from Traverse City? _____

If yes, what is the approximate month of your return to Traverse City? _____