New Pt gyno

PATIENT QUESTIONNAIRE

Patient Name: ______________________ Date of Birth: __________ Age: ___ Primary Care Physician: ______________

Date: ____________________ Main reason for today's visit: ______________________________________

Were you referred by a doctor? If so, who? ____________________________ How did you hear about us? ______________

Do you have a religious preference? ________________________ What is your race or ethnic background? ______________

Pharmacy name, location, phone number: ____

Medications: List all prescription medications and vitamins you currently take, with their dosages:

Allergies: List all allergies you have, along along with your reactions to them:

Social History:

SMOKING	Used to	Currently
# packs per day		
# years smoking		
Did you quit? When?		
DRINKING	Used to	Currently
# occasions per week		
# drinks in one day		
Did you quit? When?		
USE OF RECREATIONAL DRUGS		
Do you / have you ever used drugs recreationally? *yes__ no__ If yes, list which + frequency:*		

Are you employed? *yes__ no__*

Occupation: ______________________

Any changes in home/work life recently? *yes__ no__*

If yes, list: ______________________

Are you a victim of domestic violence? *yes__ no__*

Who currently lives with you? ______________

Relationship status: ______________________

Do you exercise? *yes__ no__*

If yes, what kind? ______________

How often? ______________

Are you currently experiencing little interest or pleasure in doing things? *Circle one:*

Not at all – Several days – More than ½ the days – Nearly every day – Decline to specify

Are you currently feeling down, depressed, or hopeless? *Circle one:*

Not at all – Several days – More than ½ the days – Nearly every day – Decline to specify

GYN History:

Last pap smear *date + result*: ______________________

Have you ever had an abnormal pap result? *yes__ no__*

If yes, list date and treatment: ______________________

Birth control method: ______________________

Have you used a different method of birth control in the past? *yes_ no_*

If yes, please specify: ______________________

Last colonoscopy *date + result*: ______________________

Last bone density scan *date + result*: ______________________

Last mammogram *date + result*: ______________________

Date of last menstrual period: ______________________

Date of last flu shot: ______________________

Have you gotten all 3 Gardasil shots? *yes__ no__ don't know__*

Sexual orientation: Heterosexual – Bisexual – Homosexual – Other

At what age did you start menstruation? ______________

Have you ever been diagnosed or treated for:

Infertility- *yes__ no__* Ovarian cysts- *yes__ no__*

Fibroids- *yes__ no__* Endometriosis- *yes__ no__*

Indicate which of the following conditions you have a history of:

yes__ no__ Gonorrhea

yes__ no__ Genital warts

yes__ no__ Chlamydia

yes__ no__ Syphilis

yes__ no__ Herpes (specify genital or non-genital)

yes__ no__ Pelvic inflammatory disease

yes__ no__ HIV

If yes, list what treatment you received

If you HAVE NOT gone through menopause:
Date of last period:
How often do they come?
How many days do they last?
Flow: light, moderate, or heavy?
Any pain with periods?
If you HAVE gone through menopause:
When did you stop having periods?
Have you ever been evaluated for bleeding after menopause?
Have you ever taken hormone replacement therapy?

Please circle any of the following conditions you are currently experiencing:

NEUROLOGICAL	RESPIRATORY	GASTROINTESTINAL	CONSTITUTIONAL	URINARY	ENT	SKIN
Headaches	Shortness of breath	Bloody stool	Weight loss	Urination frequency	Hearing loss	Itching
Memory problems	Chronic cough	Nausea/vomiting	Weight gain	Pain with urination	Hearing problems	Burning
Numbness/tingling	Coughing up blood	Diarrhea	Fever	Leaking of urine	Congestion	Rash
Seizure disorder	Difficulty/pain breathing	Constipation	Fatigue	Bloody urine	Sore throat	
Blurred vision						

PSYCH	MUSCULOSKELETAL	HEMO/LYMPH	CARDIOVASCULAR	EYES	REPRODUCTIVE	ENDO
Depression	Muscle/joint pain	Bruising/bleeding	Chest pain	Vision changes	Irregular menses	Cold intolerance
Crying spells	Swelling of joints	Anemia	Irregular heart beat	Double vision	Menopause	Thyroid problems
	Bone loss	Swollen lymph nodes	Swollen legs	Glasses	Sexual dysfunction	

Main reason for today's visit:____

Patient & Family Medical History: Mark ONLY conditions you have had in the past, currently have, & those which you have family history of

Your current issue? Indicate YES's only	*Your* past issue? Indicate YES's only	Condition	Family History? Indicate YES's only	*If YES:* Family member alive or deceased + relation (maternal or paternal) + age
		Diabetes		
		Hypertension		
		High Cholesterol		
		Bone loss		
		Autoimmune disorder		
		Epilepsy/Seizure disorder		
		Hepatitis/Liver disease		
		Migraines		
		Kidney disease		
		UTIs		
		Asthma		
		Heart disease		
		Blood clot in lungs		
		Psychiatric disorders		
		AIDS		
		Trauma or violence		
		Sickle cell trait/disease		
		Anemia		
		Bleeding disorder		
		Tuberculosis		
		Vascular/thromboembolic		
		Thalassemia		
		Thyroid dysfunction		
		Depression		
		Stroke		
		Heart attack		
		Down Syndrome		
		Congenital heart defects		
		Neural tube defects		
		Hydrocephalus		
		Muscular dystrophy		
		Developmental delay		
		Cystic fibrosis		
		Osteopenia		
		Cleft palate or lip		
		Infertility or DES		
		Deafness		
		Blindness		
		Hemophilia		
		Breast cancer		
		Colon cancer		
		Ovarian cancer		
		Uterine cancer		
		Other cancer		

Patient OB/Pregnancy History

COVID VACCINE:
YES: NO:

Total # of pregnancies______________ Total # of living children: _______________

Deliveries:

Date	Weeks at delivery	Labor time (hrs)	Birth weight	Sex of baby	Route of delivery	Anesthesia: natural, IV, epidural, etc	Hospital	Child OK (x if no)	Premature labor (x if yes)

Hospital + Surgical History:

Have you ever received a blood transfusion? *yes___ no___*
Have you ever been hospitalized overnight? If so, for what?

Have you ever had surgery? List all surgeries and biopsies, along with their dates:

Office use only- Ht:______ Wt:______ BP:______ Temp:______