

Date: \_\_\_\_\_

### PATIENT QUESTIONNAIRE – NEW GYN PATIENT

The purpose of obtaining this information is to develop a comprehensive picture of your background. By completing these questions to the best of your ability, you will make it possible for your doctor to evaluate and treat you in the best clinical manner. This sheet will become a part of your medical record and will therefore be considered CONFIDENTIAL INFORMATION.

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Physician Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

First day of your last menstrual period (LMP): \_\_\_\_\_

What are you currently using to prevent pregnancy? \_\_\_\_\_

What is your Reason for Visit today? \_\_\_\_\_

**GYN HISTORY: Please check all that apply.**

Have you ever had any of the following sexually transmitted diseases? If so, when and were you treated?

<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	HIV	<input type="checkbox"/>	Trichomonas
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	HPV	<input type="checkbox"/>	Venereal Warts

**PERSONAL PAST HISTORY: Please check all that apply.**

<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Cancer: (specify)	<input type="checkbox"/>	Frequent Bladder Infections	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Clotting Disorder	<input type="checkbox"/>	Frequent Kidney Infections	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>		<input type="checkbox"/>	

Other: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

**ALLERGIES/DRUG ALLERGIES:** Please list and include reactions. \_\_\_ NONE \_\_\_ Latex \_\_\_ Band-Aids \_\_\_ Rubber Gloves

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS (with dose, frequency and reason):** List medications you are currently taking. \_\_\_ No Current Medications

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Additional Medications:

FAMILY MEDICAL HISTORY	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Other
Bleeding/Clotting Disorder							
Breast Cancer							
Colon Cancer							
Heart Disease							
High Blood Pressure							
Diabetes							
Osteoporosis							
Uterine Cancer							
Ovarian Cancer							
Cervical Cancer/Dysplasia							
Fibroids							
Endometriosis							

**PERSONAL HABITS/SOCIAL HISTORY:**

**Marital Status:**  Single  Engaged  Married  Widowed  Separated  Divorced  Living with significant other

**Tobacco Use:**  Never Smoker  Former Smoker  Current Smoker  packs per day for \_\_\_ years / Quit \_\_\_ yrs ago

**Caffeine Use:**  None  Coffee  Tea  Carbonated beverages  Medicines  Foods \_\_\_\_\_ Servings per day

**Alcohol Use:**  None  Occasional Use  Moderate Use  Heavy Use \_\_\_\_\_ drinks per week

**Did you have intercourse before the age of 16?**  Yes  No

**Have you had 5 or more sexual partners?**  Yes  No

**Have you ever been touched or forced to have sexual contact with someone against your will?**  Yes  No

**PREGNANCY/BIRTH HISTORY:**

	Date	M – miscarriage A- abortion E - ectopic	Gestational Age (# of weeks pregnant upon delivery)	Birth Weight	Sex (M or F)	V – vaginal C – Cesarean Section	Complications
Pregnancy 1							
Pregnancy 2							
Pregnancy 3							
Pregnancy 4							
Pregnancy 5							
Pregnancy 6							
Pregnancy 7							

**PAST SURGICAL HISTORY: Please list (except for pregnancy).**

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**REVIEW OF SYSTEMS:** *Currently do you have any problems with the symptoms listed below. Please circle YES or NO:*

<u>GENERAL</u>			<u>FEMALE GENITOURINARY</u>		
Fatigue	YES	NO	Blood in Urine	YES	NO
Fever	YES	NO	Excessive Menstrual Bleeding	YES	NO
Weight Loss	YES	NO	Amenorrhea (no periods for 3 months)	YES	NO
<u>SKIN</u>			Bleeding after menopause	YES	NO
Rash	YES	NO	Bleeding between periods or after intercourse	YES	NO
Change in Wart/Mole	YES	NO	Burning with Urination	YES	NO
<u>HEENT</u>			Frequent Yeast Infections	YES	NO
Deafness	YES	NO	Incontinence (leakage of urine)	YES	NO
Mouth/Tongue Sores	YES	NO	Infertility (difficulty getting pregnant)	YES	NO
Sinusitis	YES	NO	Painful Intercourse	YES	NO
Visual Loss	YES	NO	Painful Menstruation/Periods	YES	NO
Wears glasses/contacts	YES	NO	Pelvic Pain	YES	NO
Voice Changes	YES	NO	Sexual Difficulties	YES	NO
<u>RESPIRATORY</u>			Straining with Urination	YES	NO
Cough	YES	NO	Urinary Urgency	YES	NO
Wheezing	YES	NO	Urinating at Night/How often: _____	YES	NO
<u>BREAST</u>			<u>MUSCULOSKELETAL</u>		
Breast Mass	YES	NO	Back Pain	YES	NO
Breast Tenderness	YES	NO	Joint Pain	YES	NO
Nipple Discharge	YES	NO	<u>NEUROLOGICAL</u>		
<u>CARDIOVASCULAR</u>			Convulsions	YES	NO
Chest Pain	YES	NO	Decreased Memory	YES	NO
Irregular Heart Beat	YES	NO	Migraines	YES	NO
Palpitations	YES	NO	Paralysis	YES	NO
Difficulty Breathing on Exertion	YES	NO	Trouble Sleeping	YES	NO
Swelling of Extremities	YES	NO	<u>PSYCHIATRIC</u>		
<u>GASTROINTESTINAL</u>			Anxiety	YES	NO
Abdominal Pain	YES	NO	Depression	YES	NO
Constipation	YES	NO	<u>ENDOCRINE</u>		
Diarrhea	YES	NO	Excessive Thirst	YES	NO
Hemorrhoids	YES	NO	Excessive Urination	YES	NO
Nausea	YES	NO	<u>HEMATOLOGY</u>		
Rectal bleeding	YES	NO	Easy Bruising	YES	NO
Vomiting	YES	NO	Nosebleeds	YES	NO
			Swollen Glands	YES	NO