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GYNECOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name _____ Date of Birth ____/____/____ Date ____/____/____

PAST MEDICAL & FAMILY HISTORY Please check (✓) if you (SELF) or any blood relative (FAM) had any of the following conditions.

	SELF	FAM	EXPLAIN		SELF	FAM	EXPLAIN
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Heart / Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>		Anemia / Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Disease	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		DVT / Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary (Lung) / Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Uterine or Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux / Ulcer	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy / Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Disease / Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis - Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis / Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>		Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>		Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	
STD	<input type="checkbox"/>	Partner? <input type="checkbox"/>					

DRUG ALLERGIES?

VACCINES Chicken Pox Childhood Vaccines HPV Hepatitis A Hepatitis B Last Tetanus _____

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY Give the year of the procedure and explain.

MEDICATIONS List all medications you are currently taking.

ALLERGIES & REACTIONS

MENSTRUAL HISTORY Age at first period? _____ 1st day last period? ____/____/____ Cycle length? _____ Duration of bleeding? _____

Cramps? Y N If yes: Mild Moderate Severe Always Present Bleeding? Light Moderate Heavy

Hot Flashes? Y N If yes, treatment _____

PAP Last test ____/____/____ Ever had abnormal result? Y N **MAMMOGRAM** Last test ____/____/____ Ever had abnormal result? Y N

CONTRACEPTION Current Method _____ **ARE YOU CONSIDERING GETTING PREGNANT IN THE FUTURE?** Y N

OBSTETRICAL HISTORY # of Pregnancies _____ Premature Babies _____ Miscarriages _____ Abortions _____ Living Children _____

BIRTH DATE	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BIRTH DATE	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS
1						4					
2						5					
3						6					

SOCIAL HISTORY Smoking - Cig./Day _____ # Years _____ Alcohol - Oz./Week _____ Caffeine - Cups/Day _____ Street Drugs _____