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: _____ Today's Date: _____

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?

	Chlamydia		Herpes		Syphilis
	Gonorrhea		HIV		Trichomonas
	Hepatitis		HPV		Venereal Warts

PERSONAL PAST HISTORY: Please check all that apply.

	Abnormal Pap Smear		Asthma		Endometriosis		Hypertension
	Alcoholism		Cancer: (specify)		Frequent Bladder Infections		Liver Disease
	Anemia		Clotting Disorder		Frequent Kidney Infections		Rheumatic Fever
	Anxiety		Depression		Heart Murmur		Thyroid Disease
	Arthritis		Diabetes Mellitus				
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).

_____

_____

_____

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

GENERAL			**FEMALE GENITOURINARY**		
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**
SKIN			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**
HEENT			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**
RESPIRATORY			Straining with Urination	**YES**	**NO**
Cough	**YES**	**NO**	Urinary Urgency	**YES**	**NO**
Wheezing	**YES**	**NO**	Urinating at Night/How often: _____	**YES**	**NO**
BREAST			**MUSCULOSKELETAL**		
Breast Mass	**YES**	**NO**	Back Pain	**YES**	**NO**
Breast Tenderness	**YES**	**NO**	Joint Pain	**YES**	**NO**
Nipple Discharge	**YES**	**NO**	**NEUROLOGICAL**		
CARDIOVASCULAR			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**	**PSYCHIATRIC**		
GASTROINTESTINAL			Anxiety	**YES**	**NO**
Abdominal Pain	**YES**	**NO**	Depression	**YES**	**NO**
Constipation	**YES**	**NO**	**ENDOCRINE**		
Diarrhea	**YES**	**NO**	Excessive Thirst	**YES**	**NO**
Hemorrhoids	**YES**	**NO**	Excessive Urination	**YES**	**NO**
Nausea	**YES**	**NO**	**HEMATOLOGY**		
Rectal bleeding	**YES**	**NO**	Easy Bruising	**YES**	**NO**
Vomiting	**YES**	**NO**	Nosebleeds	**YES**	**NO**
			Swollen Glands	**YES**	**NO**