

# New Patient Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Account #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Husband's Occupation: \_\_\_\_\_

**DIRECTIONS:** Please circle, check ( ) or fill in the blanks with the answers best describing your situation.  
All information will be held confidential and used to provide proper care.

Reason for seeing doctor: \_\_\_\_\_

## OBSTETRICAL AND GYNECOLOGIC HISTORY:

1. How old were you when you first started your period? \_\_\_\_\_
2. Do you have pain with your period? YES NO  
If yes, when do you have pain? (Before, During, After) \_\_\_\_\_  
If yes, how long does the pain last? \_\_\_\_\_
3. Do you have swelling before your periods? YES NO
4. DATE OF THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD: \_\_\_\_\_
5. How many days pass between the first day of each period? \_\_\_\_\_ days pass
6. How long do your periods last? \_\_\_\_\_ days
7. On your heaviest day, how many pads and/or tampons do you use? \_\_\_\_\_ pads and/or \_\_\_\_\_ tampons at most  
\_\_\_\_\_ soaked \_\_\_\_\_ mild \_\_\_\_\_ moderate  
How many pads at one time? \_\_\_\_\_ pads at one time  
How many days are heavy? \_\_\_\_\_ days
8. Do you have pain with intercourse? YES NO
9. Do you have bleeding with intercourse? YES NO
10. Do you bleed between periods? YES NO
11. When was your last pap smear? \_\_\_\_\_
12. Have you ever had an abnormal pap smear? YES NO  
If Yes, What treatment was done? \_\_\_\_\_
13. Contraception (pills, condoms, etc.) \_\_\_\_\_
14. Tubal Ligation? YES NO
15. Vasectomy? YES NO
16. Last Mammogram \_\_\_\_\_

## PREGNANCY HISTORY

\_\_\_\_\_ # of Pregnancies      \_\_\_\_\_ # of Miscarriages      \_\_\_\_\_ # of Abortions      \_\_\_\_\_ # of Living Children

### Term Births:

BORN MONTH/YEAR	HOSPITAL CITY/STATE	HOURS IN LABOR	SEX	WEIGHT	TYPE OF DELIVERY	COMPLICATIONS
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____

## MEDICAL HISTORY

1. Please list any type of surgery you have had and the year of the surgery:  
\_\_\_\_\_  
\_\_\_\_\_
2. Please list any other hospitalization you have had and the reason (not including childbirth):  
\_\_\_\_\_  
\_\_\_\_\_
3. Did you have any childhood diseases? YES NO If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

(continued on reverse)

## MEDICAL HISTORY (CONTINUED)

4. Last Colonoscopy \_\_\_\_\_
5. Age 65 and older: Pneumovax Immunization YES NO If yes, when: \_\_\_\_\_  
Date of last tetanus shot: \_\_\_\_\_
6. Please list any medications you are now taking, the dosages, and reason for medication. Include over the counter medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Are you allergic to any medications, latex or iodine? YES NO If yes, please list & describe how you react to them: \_\_\_\_\_  
\_\_\_\_\_
8. Have you ever had any injuries (i.e. broken bones, concussions)? YES NO If yes, please list: \_\_\_\_\_  
\_\_\_\_\_
9. Have you ever had a blood transfusion? YES NO If yes, when \_\_\_\_\_
10. Do you have or have you ever had any problems with any of the following? Check (✓) appropriate line and explain positive finding below.
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Eyes, Ears, Nose and Throat   | <input type="checkbox"/> Bowel Problems                | <input type="checkbox"/> Phlebitis                                      |
| <input type="checkbox"/> Thyroid Disease               | <input type="checkbox"/> Kidney Disease                | <input type="checkbox"/> Blood Clots in Legs or Lungs                   |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Urinary Tract Infections      | <input type="checkbox"/> Genital Herpes                                 |
| <input type="checkbox"/> Breast                        | <input type="checkbox"/> Mental Disorders              | <input type="checkbox"/> Gonorrhea                                      |
| <input type="checkbox"/> Asthma, Bronchitis, Pneumonia | <input type="checkbox"/> Seizure Disorders             | <input type="checkbox"/> Syphilis                                       |
| <input type="checkbox"/> Heart Disease or Murmur       | <input type="checkbox"/> Migraine Headaches            | <input type="checkbox"/> Condyloma (Warts)                              |
| <input type="checkbox"/> Heart Attack                  | <input type="checkbox"/> Anxiety Disorder, Depression  | <input type="checkbox"/> Chlamydia                                      |
| <input type="checkbox"/> High Cholesterol              | <input type="checkbox"/> Blood Disorder, Easy Bruising | <input type="checkbox"/> AIDS or HIV Exposure                           |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Trichomonas                                    |
| <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Hemophilia                    | <input type="checkbox"/> DES Exposure - Did your mother take it? YES NO |
| <input type="checkbox"/> Liver Disease, Hepatitis      | <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Cancer (Specify) _____                         |
| <input type="checkbox"/> Stomach Problems              | <input type="checkbox"/> Varicosities                  | <input type="checkbox"/> Other _____                                    |

DETAIL POSITIVE FINDINGS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Care Physician (Family Practitioner or Internist): \_\_\_\_\_

Last Exam: \_\_\_\_\_

Other Specialists you see: \_\_\_\_\_

## FAMILY HISTORY

Are you adopted? YES NO

If any family member has had any of the problems indicated above (SEE QUESTION #10), please list problem(s) on appropriate line.

	Problems	If Deceased, Cause of Death	Age at Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____
Grandparents:	_____	_____	_____
Other:	_____	_____	_____

## HEALTH HISTORY

1. Number of caffeine drinks per day (coffee, tea, soda): \_\_\_\_\_
2. Number of alcoholic drinks per day (beer, wine, liquor): \_\_\_\_\_  
Do you feel you have a drinking problem? YES NO
3. Smoking: Never \_\_\_\_\_ Quit (when) \_\_\_\_\_ Yes (number per day) \_\_\_\_\_ How many years? \_\_\_\_\_
4. Street drugs (cocaine, marijuana, others) \_\_\_\_\_ YES NO If yes, what and how often? \_\_\_\_\_  
Do you feel you have a street drug or prescription pain drug problem? \_\_\_\_\_
5. Calcium servings (milk, cheese, yogurt, etc.) or supplements (mg.) per day: \_\_\_\_\_
6. Do you perform monthly breast self exams? YES NO
7. What do you do for exercise? \_\_\_\_\_  
Frequency per week and duration: \_\_\_\_\_
8. Do you have any sex related concerns? \_\_\_\_\_
9. Have you ever been sexually or emotionally abused? YES NO
10. Are you interested in HIV (AIDS), Syphilis or other sexually transmitted disease testing? YES NO If yes, which one: \_\_\_\_\_
11. Do you feel you need treatment for anxiety/depression? YES NO