



NEW GYN PATIENT QUESTIONNAIRE (01/11)

Please provide the following information to help us provide you complete and efficient care.

DATE: _____ INSURANCE: _____
 NAME: _____ OCCUPATION: _____
 ADDRESS: _____ MARITAL STATUS: _____
 _____ PRIMARY CARE PHYSICIAN: _____
 [] HOME PHONE # _____ EMERGENCY CONTACT NAME & PHONE # _____
 [] WORK PHONE # _____
 [] CELL PHONE # _____

PLEASE CHECK PREFERRED DAYTIME CONTACT

1. What is the purpose of your visit today? Please list any issues or questions that you desire to be addressed.

- _____
- _____
- _____

2. Have you ever been pregnant? If yes, please provide the following information about your pregnancies.
 If no, proceed to question #3 I have never been pregnant.

Number of full term births (37 weeks and later) _____
 Number of preterm births (less the 37 weeks) _____
 Cesarean births _____
 Vaginal births _____
 Live births _____
 Children presently living _____
 Number of ectopic (tubal) pregnancies _____
 Number of miscarriages _____
 Number of elective abortions _____

3. Are you currently pregnant? Yes No Unsure N/A (menopausal)
4. When was the first day of your last menstrual period? _____ N/A (menopausal)
5. If menopausal, what was your age at the time of your menopause? _____
 Was your menopause Natural Surgical Premature Medically induced Other
6. Have you had a hysterectomy? Yes No
7. Have you been evaluated or treated for abnormal pap smears? Yes No
 If treatment was required, what type of treatment was performed? _____
 When was the treatment performed? _____
8. Are you currently using contraception? Yes. What type? _____ No N/A

MEDICATIONS

Please list current medications and dosage if known: (include prescription medication and over-the-counter medications and supplements)

List any medical allergies and type of reaction: I have NO KNOWN MEDICAL ALLERGIES.

MEDICAL/SURGICAL HISTORY

Please list any medical problems for which you have been evaluated or treated:

Please list all prior surgeries and approximate dates:

REVIEW OF SYSTEMS – Have you had any recent problems with any of the following?

- Abdominal pain No Yes Unexplained weight loss No Yes
- Blood in stool No Yes Unexplained weight gain No Yes
- Change in bowel habits No Yes Psychiatric symptoms No Yes
- Painful periods No Yes Breast discharge No Yes
- Heavy periods No Yes Breast lump No Yes
- Pain with intercourse No Yes Breast pain No Yes
- Difficulty with intercourse No Yes
- Loss of control of urine No Yes Night sweats No Yes
- Loss of control of stool No Yes Shortness of breath No Yes
- Vaginal discharge No Yes Chest pain No Yes
- Vaginal irritation No Yes Headaches No Yes
- Vulvar complaints No Yes History of blood clots No Yes
in leg or lungs

FAMILY HISTORY - Do you have immediate family member with any of the following conditions:

- Breast cancer No Yes - relationship _____
- Ovarian cancer No Yes - relationship _____
- Colon cancer No Yes - relationship _____
- Uterine cancer No Yes - relationship _____
- Diabetes No Yes - relationship _____
- Heart disease No Yes - relationship _____
- Blood Clot No Yes - relationship _____
- Stroke No Yes - relationship _____
- Osteoporosis No Yes - relationship _____
- Alzheimer's No Yes - relationship _____

HABITS

- Do you smoke? Never Quit Yes - how much _____
- Do you drink alcohol? Never Quit Yes - how much _____
- Do you use street drugs? Never Quit Yes - what _____

PREVENTIVE SCREENING

- When was your last pap smear? _____ Was it normal? Yes No
- If over the age of 40, have you had a mammogram? Yes No N/A
- When was your last mammogram? _____
- Where was the study performed? _____
- Have you ever had an abnormal mammogram? Yes No
- If over the age of 50, have you had screening for colon cancer? Yes No N/A
- When _____ What type of study _____
- Have you had a study to evaluate your bone density? Yes No
- When was your last study? _____