



SCOTT & WHITE

NEW GYN PATIENT QUESTIONNAIRE

Patient Identification _____

6. Please list all prior surgeries and approximate dates:

7. Are you having any complaints of PAIN? If yes, where?

Please rate severity Least pain - 1 2 3 4 5 6 7 8 9 10 - Most pain

MEDICATION

Please list current medications and dosage if known (include prescription medication and over-the-counter medications and supplements): _____ I have no known medical allergies.

FAMILY HISTORY – Do you have any immediate family members with any of the following conditions?

Breast cancer:	_____ Yes	_____ No	Relationship _____
Ovarian cancer:	_____ Yes	_____ No	Relationship _____
Colon cancer:	_____ Yes	_____ No	Relationship _____
Uterine cancer	_____ Yes	_____ No	Relationship _____
Diabetes	_____ Yes	_____ No	Relationship _____
Heart disease:	_____ Yes	_____ No	Relationship _____
Blood clot:	_____ Yes	_____ No	Relationship _____
Stroke;	_____ Yes	_____ No	Relationship _____
Osteoporosis:	_____ Yes	_____ No	Relationship _____
Alzheimer's	_____ Yes	_____ No	Relationship _____



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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 How much? _____

CANCER SCREENING

When was your last pap smear? _____ Was it normal? _____ Yes _____ No

Have you ever had an abnormal pap smear? _____ Yes _____ No

Have you ever undergone treatment for an abnormal pap smear? _____ Yes _____ No

What type of treatment? _____

If over the age of 35, have you ever had a mammogram? _____ Yes _____ No _____ N/A

When was your last mammogram? _____ Where? _____

Have you ever had an abnormal mammogram? _____ Yes _____ No

If over age 50, have you ever been screened for colon cancer? _____ Yes _____ No _____ N/A

When? _____ What type of study? _____