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

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 _____