Patient NAME: _____

Date of Birth: _____

New Patient Questionnaire

Name:	Age:	Marital Status: S M D W
Employer: Position:		
Reason for Visit		

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Colonoscopy		Gardasil Did you receive all 3?		Bone Density Scan?	
Pap Test		Mammogram		HIV test?	

Was last pap: □Normal □Abnormal

Any previous abnormal Paps? date _____ Treatment _____

PAST MEDICAL HISTORY: please check (X) ALL areas that apply to you.

Vaginal Infections - History of : □Trichomonas□ Chlamydia □ Herpes □ Gonorrhea□Other STDs

Arthritis	High blood pressure	Skin disease
Asthma	Kidney/bladder problems	Thyroid disease
Anemia / blood disorder	Cancer	Urinary incontinence
Bowel/Stomach disorders	Type: _____	Other
Diabetes	Seizures/epilepsy	
Hepatitis	Serious injuries	
Heart disease	Severe headaches	

SURGERIES (excluding pregnancy)

Year	Description	Year	Description

Medications'

DRUG ALLERGIES	REACTION

FAMILY HISTORY: Have any of your close relatives had any of the following conditions?

Condition:	Relation to you	Condition:	Relation to you
□ Blood disorder		□ High blood pressure	
□ Breast cancer		□ Kidney disease	
□ Cancer		□ Lung disease	
□ Diabetes □ Heart attack/Heart disease		□ Ovarian cancer □ Stroke	

SOCIAL HISTORY

Smoking □ Yes □ No (# cigs. Per day?)

Alcohol □ Yes □ No ____Drinks/Week

Street drug□ Yes □ No Type:

Caffeine Tea/Coffee _____ cups/day Colas _____cans/day

Exercise: □ None _____times per week Activity:

Sexual History: □ Satisfactory □ Uncomfortable □ Wish to discuss

MENSTRUAL HISTORY

Age at 1st period _____

Date of last period (1st day) _____ Period Interval (1st day to 1st day) # of days _____ Duration of bleeding: # of Days _____

□ Mild □ Moderate □ Severe Medication for cramps _____

Menopausal Yes, I am□Pre□ Post or □ None

Have you had a hysterectomy? □ Yes □ No

Contraceptive History:

Current Method:

Past methods:

OBSTETRICAL HISTORY

Total Preg:_____ Full Term Births_____ Premature Births_____ No. of Abortions Induced _____

No. of Abortions: Spontaneous_____ Ectopic Births _____ Multiple Births (twins) _____ Living Children_____

Month / Day / Year	Weeks Preg.	We	Sex	Type of Delivery
1)				
2)				
3)				
4)				
5)				
6)				

ANY ADDITIONAL INFORMATION YOU WISH TO SHARE:

PLEASE CHECK (X) IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING…

CONSTITUTIONAL

 Weight loss Weight gain Fever Fatigue

EYES

 Double vision Spots before eyes Vision changes

EARS, NOSE, THROAT

 Ear aches Ringing in ears Sinus problems

 Sore throat Mouth sores Dental problems

BREASTS

 Pain in breast Discharge Masses Implants

MOOD

 Anxiety Depression Frequent crying spells

CARDIOVASCULAR

 Painful breathing Chest pain Difficult breathing on exertion Swelling of legs

 Palpitations of heart

RESPIRATORY

 Wheezing Spitting up blood Shortness of breath Cough, chronic

GASTROINTESTINAL

 Frequent diarrhea Bloody stool Nausea/vomiting Constipation

GENITOURINARY

 Blood in urine Pain with urination Urgency Frequency of urination

 Incomplete emptying Stress incontinence Abnormal periods Painful intercourse