



New Patient History Questionnaire

Please answer all questions carefully and completely prior to your visit. Answers are confidential.

Name: _____ Today's Date: _____ Date of Birth: _____

Marital Status: Single Married Divorced Widowed Cohabiting Spouse or partner's name: _____

Highest grade completed in school? (circle) 7 8 9 10 11 12 13 14 15 16 17 18 19 20 +

Occupation? _____ **Would you like a female chaperone? Yes () No ()**

Medical History: Please indicate whether you (Me) or someone closely related (R) to you have had any of these medical

#	Me	R	Condition	#	Me	R	Condition	#	Me	R	Condition	#	Me	R	Condition
1			heart attack	14			cancer	27			seizures	40			leakage of stool
2			high blood pressure	15			gallstones	28			migraines	41			leakage of urine
3			high cholesterol	16			liver disease	29			meningitis	42			kidney problems
4			heart murmur	17			colitis	30			mononucleosis	43			UTI
5			stroke	18			ulcers	31			lupus	44			AIDS
6			arrhythmia	19			irritable bowel	32			osteoporosis	45			STD
7			emphysema	20			hernia	33			arthritis	46			psychiatric problems
8			lung infection	21			diabetes	34			severe trauma	47			substance abuse
9			asthma	22			thyroid trouble	35			infertility	48			
10			phlebitis/clots	23			hearing problems	36			abnormal PAP	49			
11			anemia	24			sinus problems	37			endometriosis	50			
12			hemophilia	25			glaucoma	38			fibroids	51			
13			transfusions	2 6			multiple sclerosis	39			pelvic pain	52			

Do you have any **allergies** to drugs or other substances?..... YES / NO Please list, and indicate reaction(s):

Any past (non surgical) **hospitalizations**?..... YES / NO Please indicate dates and reasons:

Please list any **surgeries** you have had and the dates they occurred:

If you have had a hysterectomy, why? _____

Please list any **medications** you are on now, including doses and Frequency:

DOCTOR'S NOTES:

Gynecologic history: Age when periods started: _____ Age at menopause: _____

Total number of pregnancies: _____	Livebirths: _____	Stillbirths: _____	Miscarriages: _____	Abortions: _____
------------------------------------	-------------------	--------------------	---------------------	------------------

DOCTOR'S NOTES:

Date	GA weeks	labor hrs.	birth weight	sex	type of delivery	anes-thesia	place of delivery	Preterm labor?	comments

YES / NO Are you content with your sex life?

How many sexual partners have you had in the past year? _____ (circle) male female

If you are in your reproductive years:

Date last menstrual period began: _____ and the one before that? _____

Usual interval between the first day of one period and the first day of the next: _____ days.

Usual duration of period: _____ days Cramping? YES / NO (circle) none mild moderate severe

Anything used for cramps?..... YES / NO _____

The flow can be heavy (fills a pad or more an hour) YES / NO (circle) never sometimes usually

YES / NO Are you regularly using contraception for sexual activity? (circle type) the pill / minipill / Depo-Provera tubal ligation / vasectomy / IUD / diaphragm / condom / Implanon / natural / cap / ring / patch

If menopausal, years since last period? _____ Hormone therapy used? Yes / No # Years? _____

Alcohol: Do you currently drink alcohol?..... YES / NO Quit date: _____

Glasses per week usually consumed: wine _____ beer _____ cocktails _____ other _____

Have you ever felt that you should cut down on your drinking?..... YES / NO

Have your ever felt bad or guilty about your drinking?..... YES / NO

Smoking: Have you ever been a smoker?..... YES / NO Quit Date: _____

Number of cigarettes per day smoked now: _____ In the past? _____

Other tobacco products used now? YES / NO _____ In the past? _____

Drugs: Recreational drugs used now?..... YES / NO (circle): marijuana, cocaine, heroin, speed, hallucinogen, other _____

Recreational drugs used in the past?..... YES / NO (circle): marijuana, cocaine, heroin, speed, hallucinogen, other _____

Vaccination history: Date of last tetanus booster _____

If under 40, have you had, or been vaccinated against:

YES / NO measles? YES / NO diphtheria / pertussis YES / NO Did you get a flu shot this year?

YES / NO mumps? YES / NO HPV (gardisel) YES / NO Ever had a pneumococcal vaccine?

YES / NO rubella? YES / NO shingles / zoster

Emotional health: Have you been experiencing any emotional or mood problems? YES / NO

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed,

or when you lost all interest or pleasure in things that you usually cared about or enjoyed? YES / NO

Alternative medicine Do you use any alternative or complementary forms of medicine? YES / NO

(circle) herbal remedies acupuncture homeopathy therapeutic touch chiropractic magnetic medical marijuana

Other: _____

Name: _____

Safety: Please answer the following:

- YES / NO Do you wear seatbelts regularly?
- YES / NO If you cycle, do you wear a bicycle/motorcycle helmet?
- YES / NO Do you have smoke detectors in your home?
- YES / NO If you smoke detector has batteries, have you checked/changed them in the last year?
- YES / NO Are there adequate handrails for any stairs in your home?
- YES / NO **If** you have young children, is the thermostat on your water heater turned down?
- YES / NO **If** you own a gun,, is it secured away from children?
- YES / NO Do you practice safe sex (monogamous relationship or condom use)?
- Are you being hit or verbally abused at home or elsewhere?YES / NO
- Are you now, or have you ever been forced to have sex without your consent?YES / NO

Health Maintenance

- YES / NO Do you eat a balanced diet with plenty of fruits and vegetables and low in fat?
- YES / NO Do you participate in regular physical activity or exercise? How often? _____times per week
What types of exercise?_____
- YES / NO Do you visit the dentist in the last year? How many times? _____
- YES / NO Do you brush and floss daily?
- YES / NO Has your cholesterol level ever been checked? Date: _____ Value: _____
- YES / NO Have you ever had a Pap smear? Date of most recent Pap smear:_____
- YES / NO Do you do monthly breast self exam?
- YES / NO Have you ever had a mammogram? Date of most recent mammogram: _____
- YES / NO Did you have an eye exam in the past year with glaucoma screening?
- YES / NO Do you check your skin periodically for unusual growths or changes in moles?
- YES / NO Do you wear sunscreen when out of doors?
- YES / NO If over 50 have you had a colonoscopy? Date? _____
- YES / NO If menopausal, have you had a bone density scan? Date? _____

What are your health concerns or problems today? _____

- | | | | |
|----------------------------|-----------------------------|---------------------------|--------------------------|
| ___pre-conception concerns | ___sexual difficulties | ___sexually transmissible | ___abnormal moles |
| ___cancer screening | ___nutrition | ___diseases | ___marital counseling |
| ___weight loss | ___exercise programs | ___HIV testing | ___parenting issues |
| ___smoking cessation | ___alcohol or drug problems | ___PMS | ___stress reduction |
| ___domestic violence | ___incontinence (urine or | ___vaginitis | ___depression counseling |
| ___home safety | stool leakage) | ___menopause | ___cholesterol |
| ___contraceptive options | ___safe sex | ___vaccinations | ___fibroids |
| ___infertility | ___hormone replacement | ___breast exam | ___ |
| ___menstrual difficulties | ___osteoporosis | ___vitamin supplements | ___ |

Patient signature: _____ **Date:** _____ **THANK YOU!**

DOCTOR'S NOTES:

Clinician Signature _____ **Date:** _____