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Patient Name: _____
Date of Birth: _____

NEW PATIENT QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

HEALTH HISTORY

Past Medical History: Please circle any medical conditions that you have been diagnosed with.

Anxiety	Fibroids	Liver disease
Arthritis	Fibromyalgia	Osteoporosis
Asthma	Gout	Ovarian cysts
Bleeding Disorder	Heart attack	PCOS
Blood clots	Heart murmur	Pulmonary embolism
Cancer	Hiatal Hernia	Reflux or ulcers
Coronary Artery Disease	HIV or AIDS	Stroke
Claustrophobia	High cholesterol	Thyroid disease
Depression	High blood pressure	Tuberculosis
Diabetes (insulin dependent)	Infertility	Other
Diabetes (non-insulin dependent)	Kidney disease	_____
Dialysis	Kidney stones	_____
Diverticulitis	Leg/foot ulcers	_____
Endometriosis	Lupus	_____

Past Surgical History: Please list any surgeries you have had.

SURGERY	REASON	YEAR	LOCATION

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Gynecologic History: Please complete all fields that apply.

Date of LMP: _____
Cycle frequency (days): _____
Duration of flow (days): _____
Flow amount:

- ☐ Light
- ☐ Medium
- ☐ Heavy

Menses monthly? Y or N
Menstrual cramps:

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Age of first period: _____
Age of menopause: _____

Any history of breast problems? Y or N
Date of last mammogram: _____
Date of last DEXA scan: _____
Date of last colonoscopy: _____

Are you currently using contraception? Y or N
- If so, which one? _____

Date of last pap smear: _____
History of abnormal pap? Y or N
- If abnormal, please list result if known:

_____

Any history of treatment for abnl pap? Y or N
Any history of positive HPV testing? Y or N
Received Gardasil vaccine? Y or N

Any history of STI/STDs? Y or N
- If yes, please list which one and when:

_____

_____

Any history of pelvic procedures? Y or N
- if yes, please list _____

Sexual orientation: _____
Are you currently sexually active? Y or N
Number of lifetime sexual partners? _____
Any sexual problems? Y or N
- If yes, please describe: _____

_____

Obstetric History: Please complete all fields that apply ([please use back if more space is needed).

	Delivery date	# of fetuses (single, twins, triplets)	Outcome (full term, premature, miscarriage, ectopic, etc)	Delivery location	Delivering OB/GYN	Birth weight (in lb & oz)	Type of delivery (vaginal, c/s, forceps, VBAC)	# of weeks at time of delivery	Hours in labor	Name of baby
1										
2										
3										
4										
5										
6										

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Please list any complications you experienced during any pregnancy or delivery.

_____
_____
_____

Social History: Please complete all fields that apply.

Do you use tobacco? Y or N
If not currently, any history of tobacco use? Y or N

- ☐ Cigarettes- # pack per day _____
- ☐ Chew- _____/day
- ☐ Cigars- _____/day
- ☐ # of years? _____ (or year quit? _____)

Do you drink alcohol? Y or N
If so, how often?

- ☐ Occasionally/socially
- ☐ <3 times per week
- ☐ >3 times per week

# of drinks per week? _____

Do you drink caffeine? Y or N
How many cups/cans per day? _____

Do you exercise? Y or N
If yes, how many days/week? _____
What intensity? Light Moderate Strenuous

Level of education? _____
Occupation? _____
Marital status? _____
Religion? _____

Do you currently use recreational or street drugs? Y or N
If yes, please list _____

Family History: Please note any relatives with any of the below health conditions.

	Relative?	Onset Age?	Living or deceased?	Additional relatives?
Arthritis				
Birth defects				
Bipolar disorder				
Breast cancer				
Colon cancer				
Depression				
Diabetes				
DVT/PE				
Epilepsy				
Heart disease				
High cholesterol				
Osteoporosis				
Ovarian cancer				
Pancreatic cancer				
Stroke				
Substance abuse				
Thyroid disease				
Other:				

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_____

Medications: Please list all medications you are currently taking, including OTC meds, vitamins, and supplements. If you need more space, please continue on back of page.

MEDICATION NAME:	DOSE:	FREQUENCY:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Please list all things you are allergic to (medications, environmental, foods, etc)

ALLERGY:	REACTION:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please note any other information you would like your health care provider to know here.

_____
_____
_____
_____
_____
_____
_____

_____ _____
Patient, Parent, Caregiver, or Guardian Signature Date

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