

Metro Partners in Women's Health

The Experience You Can Trust, The Attention You Deserve

New Patient Gynecology Questionnaire

Name _____ Date _____

Age _____ Birth date _____

Names of other physicians treating you _____

What is the reason for your visit? _____

Past Gynecological History:

Last menstrual period _____ Age when periods began _____

Length of periods _____

Length of cycle (How many days from the start of one period to the start of next?) _____

Last pap smear _____ Result _____

Last mammogram _____ Result _____

Indicate if you have had any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> Excessive flow | <input type="checkbox"/> Colposcopy |
| <input type="checkbox"/> Spotting/bleeding
Between periods | <input type="checkbox"/> Cryotherapy | <input type="checkbox"/> Infertility | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Pelvic pain or pressure | <input type="checkbox"/> Discharge, itching | <input type="checkbox"/> Ovarian cyst |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Breast disease | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Hot flashes or menopause | <input type="checkbox"/> PMS | <input type="checkbox"/> IUD use |
| | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Venereal warts | <input type="checkbox"/> Herpes |

Current Birth Control/Family Planning Method _____

Do you do self breast exams? Yes / No

Are you currently sexually active? Yes / No

How many sexually partners have you had in the past year? _____

Are you trying to get pregnant? Yes / No If yes, for how long? _____

Past OB History:

Number of pregnancies _____ Number of children _____

Mo/Yr	Sex	Wt	Weeks at Delivery	Type of Delivery	Complications
#1					
#2					
#3					
#4					

Medications/Herbs/Vitamins/Supplements _____

Allergies: _____

Past Medical History:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart murmur/MVP	<input type="checkbox"/> Seizures
<input type="checkbox"/> Migraines	<input type="checkbox"/> Asthma, TB	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Other

Past Surgical History:

Surgery	Hospital	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History:

Do you work outside the home? Yes / No _____ Occupation _____

Years in your current relationship _____

Do you smoke? Yes / No	If yes, packs/day _____	For how many years _____
Do you drink alcohol? Yes / No	If yes, amount/day _____	
Do you drink caffeine? Yes / No	If yes, amount/day _____	
Do you exercise? Yes / No	If yes, what type of exercise do you do and how often? _____	

Do you always wear your seat belt? Yes / No _____
Have you been emotionally, sexually, or physically abused? Yes / No _____ If yes, please describe _____

Family Medical History:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Uterine cancer	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Other

Is your Mother alive? Yes / No _____ If not, what did she die from? _____

Is your Father alive? Yes / No _____ If not, what did he die from? _____

Number of sisters _____ Number of brothers _____

Please list any other diseases which run in your family _____

What is your nationality? _____

What do you expect from your visit today? And what other questions do you have? _____

Whom may we thank for your referral to our practice? _____

I understand this is a confidential questionnaire and I have answered it to the best of my knowledge.

Signature: _____ Date: _____

