



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 problems:

#	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	26			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:

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: _____
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DOCTOR'S NOTES:

Date	GA weeks	labor hrs.	birth weight	sex	type of delivery	anes.	place of delivery	ptl?	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 / Norplant / rhythm / cap

Comments:

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 you 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 mumps?

YES / NO rubella?

If over age 65:

YES / NO Do you get an annual flu shots?

YES / NO Ever had a pneumococcal vaccine?

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 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 you 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?

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:** _____