New Patient History Questionnaire

* we prefer you fill this out on your patient portal if possible

Name: ______________________________ Date of Birth: ______________________

Today's Date: ______________ Referred by: ______________________________

Medical History: Have you ever had any of the following?

o Anemia	o Blood Clots in Lungs/Legs	o Chicken Pox
o Pneumonia	o Heart Disease/Heart Attack	o Gall Bladder Disease
o Epilepsy/Seizures	o Tuberculosis	o High Blood Pressure
o Liver Disease/Hepatitis	o Migraines	o Sickle Cell Disease
o Stroke	o Kidney Infections	o Depression/Anxiety
o Thyroid Problems	o High Cholesterol	o Bladder Infections
o Drug or Alcohol Problem	o Blood Transfusion	o Mitral Valve Prolapse
o Pelvic Infections	o Diabetes	o Genetic Condition(s)
o Bleeding Problems	o Arthritis	o Asthma
o Cancer	o Mental Illness	o Other*

*Other major medical issues: ______________________________

Known Allergies: ______________________________

Surgical History: Please list any/all surgeries you've had with the approximate date of surgery

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Obstetrical History:

Please list pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal) pregnancies, and abortions.

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (pre-term labor, diabetes, high blood pressure, etc.)	Name/Age

- o Check here if you have **never** been pregnant
- o Check here if you have adopted children

Gyn History:

Age of first period: _____

Age of last period: _____

Cycle length: every _____ days

Periods last: ____ days

Periods are: ____ Regular ____ Irregular ____ Painful ____ Not bothersome

Flow is: ____ Light ____ Light to moderate ____ Moderate to heavy ____ Very heavy

Are you sexually active? Yes: ___ No: ___ If yes, please list the number of sexual partners in your lifetime: ____

Method of birth control used: ______________________________

Have you ever had any of the following STDs? Check all that apply:

o Chlamydia	o HPV	o HIV
o Gonorrhea	o Syphilis	o Hepatitis B
o Genital Herpes	o Trichomonas	o Hepatitis C

***PLEASE TURN OVER AND FILL OUT OTHER SIDE**

Do you have or have you ever had any of the following conditions? Check all that apply:

o Fibrocystic Breasts	O Endometriosis
o Ovarian Cysts	o Uterine Fibroids

Date of last Pap smear: ________________ Result of last Pap smear (normal or abnormal): ____________________

Have you ever needed or has it been medically recommended that you have any of the following procedures done due to an abnormal Pap result? Check all that apply:

o Colposcopy	o LEEP/Laser/Conization
o Cryosurgery	o Hysteroscopy
o Other: Please List:	

Date and result of last mammogram: ____

Date and result of last bone density: ____

Date and result of colonoscopy: ____

Family History: Please list any close relatives with a history of any of the following:

Condition	Relative and Age of Diagnosis
o Breast Cancer	
o Ovarian Cancer	
o Uterine Cancer	
o Colon Cancer	
o High Blood Pressure	
o Diabetes	
o Heart Disease (including heart attack, stroke, bypass surgery)	

Social History: Please circle yes or no. If yes, answer the questions appropriately:

Alcohol Use	Yes	No	Number of drinks per day/week/month:
Tobacco Use	Yes	No	Number of pack(s) per day and number of years:
Street Drug Use	Yes	No	Type and frequency:
Exercise	Yes	No	Type and frequency:
Caffeine	Yes	No	Number of caffeinated drinks per day/week:
Sexual Abuse	Yes	No	Are you safe now? Have you received counseling?
Physical Abuse	Yes	No	Are you safe now? Have you received counseling?
Emotional Abuse	Yes	No	Are you safe now? Have you received counseling?

Review of Systems: Do you currently have any of the following conditions and/or symptoms?

o Recent weight gain or loss of 25 or more lbs.	o Frequent Urination
o Fever	o Burning with Urination
o Vision Problems	o Incontinence
o Sinus Problems	o Urgency
o Hearing Loss	o Bladder Infection
o Chest Pain	o Pelvic Pain
o Varicose Veins	o Painful Sexual Intercourse
o Shortness of Breath	o Breast lumps
o Chronic Cough	o Back Pain
o Diarrhea	o Joint/Muscle Pain
o Constipation	o Depression/Anxiety
o Blood in Stools	o Heartburn/Reflux

Patient Signature: ____ **Date:** ____________________

Provider Signature: ____ **Date:** ____________________