New Patient Questionnaire

Please provide the information requested below to enable your professional healthcare provider to better assess your healthcare needs. All information on your record is confidential and cannot be released without your written permission.

Name_____ Age_____
Last First MI

Reason for visit: ☐ Routine exam ☐ Select birth control method ☐ Pregnancy or suspected pregnancy.
☐ Other:_____.

Referred by _____ Primary healthcare provider _____

PERSONAL INFORMATION

Yes	No	Have you ever had:
☐	☐	Abnormal Pap smears
☐	☐	Vaginal infections:
		☐ Yeast ☐ Trichomonas
		☐ Bacterial ☐ Other _____
☐	☐	Venereal infections (STD's):
		☐ Syphilis ☐ Gonorrhea
		☐ Chlamydia ☐ Herpes
		☐ Warts ☐ Other _____
☐	☐	HIV/AIDS
☐	☐	Hepatitis B or C
☐	☐	Endometriosis
☐	☐	Infertility
☐	☐	Have you had a partner change in the last year?
☐	☐	Are you married or partnered in any way?
☐	☐	Are you sexually active?
		☐ Male partner
		☐ Female partner
☐	☐	Are you interested in pregnancy?
☐	☐	Do you have STD concerns?

Do you:

☐	☐	Smoke
☐	☐	Use recreational drugs
☐	☐	Consume alcoholic beverages
		☐ Occasionally ☐ Daily
☐	☐	Consume caffeinated beverages
		☐ Coffee ☐ Cola ☐ Tea
☐	☐	Examine your breasts
		☐ Occasionally ☐ Regularly
☐	☐	Have you had a mammogram?

PERSONAL INFORMATION (cont.)

Date of last pelvic exam _____

Current method of birth control:

☐ Pill ☐ Patch ☐ NuvaRing
☐ IUD ☐ Depo Provera ☐ Condoms
☐ Diaphragm ☐ Tubal ligation ☐ Vasectomy
☐ Other _____ ☐ Desiring pregnancy
☐ Not sexually active

Sexual abuse as: ☐ Child ☐ Teen ☐ Adult
☐ Incest ☐ Rape ☐ Other ☐ N/A

RECENT HEALTH

Yes	No	Do you have:
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Visual problems
☐	☐	Chest pain or tightness
☐	☐	Shortness of breath
☐	☐	Palpitations or heart racing
☐	☐	Indigestion/Heartburn
☐	☐	Gas/Bloating
☐	☐	Bleeding from bowels
		☐ Bright red ☐ Black
☐	☐	Change in bowel habits
☐	☐	Bladder problems
		☐ Leakage ☐ Frequency
		☐ Burning ☐ Urgency
		☐ Foul smelling urine
		☐ Incomplete bladder emptying
☐	☐	Infertility
☐	☐	Sexual difficulty
☐	☐	Thyroid trouble
☐	☐	Diabetes

MENSTRUAL INFORMATION

Age of first menstrual period _____
First day of last period _____
Periods are: ☐ Regular ☐ Irregular
# of days of flow (average) _____
# of days from 1st day of one period to the 1st day of the next period _____

Yes	No	Do you have:
☐	☐	Cramping
		☐ Mild ☐ Moderate ☐ Severe
☐	☐	Abnormally heavy bleeding
		☐ Clots ☐ Gushes ☐ Night floods
☐	☐	PMS
		☐ Depression ☐ Lack of control
		☐ Moodiness ☐ Anxiety
☐	☐	Bleeding between periods
☐	☐	Bleeding after intercourse
☐	☐	Pain after intercourse
☐	☐	Abnormal discharge
☐	☐	Hot flashes
☐	☐	Night sweats

Medications: include prescriptions, vitamins, calcium, herbs, & over the counter medication.

Allergies to medications and herbs (or latex)

PREGNANCY HISTORY

# of pregnancies _____ Live births _____
Miscarriages _____ Abortions _____
Ectopic (tubal) pregnancies _____

SURGERIES you have had in the past

Date:	Type:	Complications:

ILLNESSES you have had in the past

Yes	No	
☐	☐	Migraine headaches
☐	☐	Seizures
☐	☐	Stroke
☐	☐	Thyroid disorders
☐	☐	Lung disorders
☐	☐	Heart disorders
☐	☐	Blood clots in legs or lungs
☐	☐	Elevated cholesterol or blood fats
☐	☐	Gastrointestinal disorders
☐	☐	Kidney/Bladder problems
☐	☐	Bone or joint disorders
☐	☐	Loss of height
☐	☐	Skin problems or cancerous growths
☐	☐	Eating disorders
☐	☐	Blood disorders
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Cancer
☐	☐	Other _____

FAMILY HISTORY

Natural mother:
☐ Living, age _____
☐ Health problems
☐ Deceased
Cause of death _____

Natural father:
☐ Living, age _____
☐ Health problems
☐ Deceased
Cause of death _____

Siblings: ☐ Brothers ☐ Sisters
☐ Health problems
☐ Deceased, age _____
Cause of death _____

Yes	No	Do you have a family history of:
☐	☐	Ovarian cancer
☐	☐	Uterine cancer
☐	☐	Breast cancer
☐	☐	Colon cancer
☐	☐	Clotting disorder
☐	☐	Heart disease

Patient Signature _____
Date _____ / _____ / _____

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