

New Patient Questionnaire

Please help us provide the best healthcare for you by completing this short form.
Your answers will become part of your medical record.

Name _____

Date of Birth _____ Age _____ Height _____

Current Medications / Supplements

None

Please list ALL medications or supplements you take:

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Rx or Over the Counter</u>
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Medical Illnesses / Major Health Problems:

None

	<u>Condition</u>	<u>Dates</u>
<input type="checkbox"/> Current <input type="checkbox"/> Past	<hr/>	<hr/>
<input type="checkbox"/> Current <input type="checkbox"/> Past	<hr/>	<hr/>
<input type="checkbox"/> Current <input type="checkbox"/> Past	<hr/>	<hr/>
<input type="checkbox"/> Current <input type="checkbox"/> Past	<hr/>	<hr/>
<input type="checkbox"/> Current <input type="checkbox"/> Past	<hr/>	<hr/>

Do you have medicine, nut, seafood, iodine or latex allergies? (please circle which one)

No Allergies

Other Allergies: _____ Reaction _____

Gynecologic History Hysterectomy (no need to answer questions re: period)

Date of LMP (first day of last period) _____ Are your periods regular? No Yes

Average number of days between menses (ex: 28 days) _____ How many days of flow _____

Average blood loss: Light Normal Heavy Cramps?: No Mild Moderate Severe

Age at the time of first menstruation _____

When was your last pap smear? _____

Ever had an abnormal pap smear? No Yes (treatment?) _____

Date of last mammogram _____, DEXA bone scan _____, colonoscopy _____

Current birth control method _____

Are you currently sexually active? No Yes

Does your sexual partner have any illnesses or STD's? No Yes (explain) _____

Any history of sexually transmitted illness? No Yes (explain) _____

Have you completed the Gardasil vaccine series? No Yes

Any questions or concerns about your sexuality or sexual relations? _____

See Reverse

Pregnancy History

Have you ever been pregnant? No Yes (please list below)

Date of delivery, type of delivery, fetal gender, fetal weight, baby's name, any complications?

#1 _____
 #2 _____
 #3 _____
 #4 _____

Surgical History None

Date of Surgery _____ Type of Surgery _____

Have you ever been hospitalized for any reason other than childbirth or surgery? No Yes

When _____ Reason _____

Family History (if positive history, please list age at diagnosis)	*Siblings* Brothers, Sisters	*Mother's side* Mom, Grandmother, Grandfather, Aunt, Uncle	*Father's side* Dad, Grandmother, Grandfather, Aunt, Uncle
Ovarian Cancer			
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
Blood Clots			
Osteoporosis			
Other -			

Mother: Alive, year of birth: _____ Deceased Unknown

Father: Alive, year of birth: _____ Deceased Unknown

Social History

Marital status? Single Married Separated Divorced Occupation: _____

Smoke? No Yes (how much) _____ Do you drink alcohol? No Yes (how much) _____

Recreational drug use? No Yes (explain) _____

Any concerns in your personal relationships? No Yes (explain) _____

Do you feel safe in your current relationship? Yes No (explain) _____

Are there any other issues you would like to share with us? _____

Are you fasting today? No Yes When did you last eat? _____

Thank You

*Office Use Only *	BP	WT
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