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:

Name	Dosage	Frequency	Rx or Over the Counter

Medical Illnesses / Major Health Problems:

☐ None

Condition	Dates
☐Current ☐Past	
☐Current ☐Past	
☐Current ☐Past	
☐Current ☐Past	
☐Current ☐Past	

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 (HPV) 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			
Uterine Cancer			
Heart Disease			
Blood Clots			
Osteoporosis			
Diabetes			
Other			

Mother: ☐Alive, year of birth:_____ ☐Deceased ☐Unknown

Father: ☐Alive, year of birth:_____ ☐Deceased ☐Unknown

Are you of Ashkenazi Jewish decent with a family history of any of the above cancers? ☐No ☐Yes

Social History

Marital status? ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed 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

06/15/2017