Welcome to

About Women by Women

Today's Date ______________

New Patient Questionnaire

Name:	Birth Date: / /
	Home Phone:
Address:	Cell Phone:
	Work Phone:
Occupation:	
Employer:	
Marital Status: ☐ Married ☐ Living w/ Partner ☐ Single ☐ Widowed ☐ Divorced	
Name of Spouse / Partner:	His/Her age:
His/Her occupation	
Emergency Contact:	Phone:
Relationship:	
Primary Care Physician:	
Who referred you to us?	
Why have you come to the office today?	

Your Current Medications
(Including hormones, vitamins, herbs and non-prescription medications)

Drug Name	Dosage	Who prescribed it?

Your Gynecologic History

First day of your last period: / /	Age periods began:
Length of periods (number of days of bleeding):	Number of days between periods:
Have you ever had sex? ☐ Yes ☐ No	Are you currently sexually active? ☐ Yes ☐ No
Are you currently sexually active? ☐ Yes ☐ No	Number of sexual partners in your life time:
Sexual partners are ☐ Men ☐ Women ☐ Either	
Current method of birth control:	
When was your last Pap test? / / Result:	
Have you ever had an abnormal Pap test? ☐ Yes ☐ No	
Do you do regular breast self-examinations? ☐ Yes ☐ No	
When was your last mammogram? / / Result:	

Name:

Your Obstetric History					
	Number		Number		Number
Pregnancies		Live births		Miscarriages	
Premature births (<37 weeks)		Living children		Abortions	

Summary of Deliveries						
	Date	Weeks Pregnant	Baby's Sex	Baby's Weight	Type of Delivery (Vag, C-Sect)	Location / Physician / Midwife
1.						
2.						
3.						
4.						

Were there any complications with any of your pregnancies? ☐ No ☐ Yes, please describe:

Your Social History and Health Maintenance			
	Y	**N**	**Notes**
Do you smoke?			_____ packs per day for _____ years
Do you drink alcohol?			_____ drinks per week
Do you wear your seatbelt?			
Do you wear sunscreen?			
Do you exercise?			_____ times per week
Do you drink caffeine?			
Does your diet include calcium?			
Does your diet include folic acid?			
Health hazards at home or work?			
Have you been hurt or threatened by anyone?			
How would you describe your diet?			
When was your last tetanus immunization?			
When was your last colorectal screening? (exam for blood in stool or sigmoidoscopy / colonoscopy)			
Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual			
Education completed: ☐ High School ☐ AA Degree / Some college ☐ College ☐ Graduate school			

Name:

Your History of Illnesses

Have *you* been diagnosed with: ☐ **Breast Cancer** ☐ **Ovarian Cancer**

Have any of your relatives been diagnosed with **Breast Cancer**? And at what age?				Have any of your relatives been diagnosed with **Ovarian Cancer**? And at what age?			
Your mother's side	Age	Your father's side	Age	Your mother's side	Age	Your father's side	Age
☐ Mother	______	☐ Father	______	☐ Mother	______	☐ Grandmother	______
☐ Your sister	______	☐ Grandmother	______	☐ Your Sister	______	☐ Aunt	______
☐ Your brother	______	☐ Grandfather	______	☐ Grandmother	______	☐ Cousin	______
☐ Grandmother	______	☐ Aunt	______	☐ Aunt	______		
☐ Grandfather	______	☐ Uncle	______	☐ Cousin	______		
☐ Aunt	______	☐ Cousin	______				
☐ Uncle	______						
☐ Cousin	______						

Are you aware of anyone in your family with prostate cancer or pancreatic cancer?

Have *you* been diagnosed with: ☐ **Colon Cancer** ☐ **Uterine Cancer**

Have any of your relatives been diagnosed with **Colon or Uterine Cancer?** At what age?				Are you aware of any relatives who have been diagnosed with other cancers?
Your mother's side	Age	Your father's side	Age	
☐ Mother	______	☐ Father	______	______________________
☐ Your sister	______	☐ Grandmother	______	______________________
☐ Your brother	______	☐ Grandfather	______	______________________
☐ Grandmother	______	☐ Aunt	______	______________________
☐ Grandfather	______	☐ Uncle	______	______________________
☐ Aunt	______	☐ Cousin	______	
☐ Uncle	______			
☐ Cousin	______			

Other Major Illness	**Yes (Date)**	**No**	**Unsure**	**Notes**
Asthma				
Pneumonia / lung disease				
Kidney infection / kidney stones				
Tuberculosis				
Sexually transmitted infection				
HIV / AIDS				
Heart attack / heart problems				

Name:

Other Major Illness	**Yes (Date)**	**No**	**Unsure**	**Notes**
Mitral valve prolapse				
High blood pressure				
Stroke				
Rheumatic fever				
Blood clots in lungs or legs				
Collagen vascular disease (Lupus)				
Chicken pox				
Diabetes				
Reflux, hernia, ulcers				
Bowel problems				
Gallbladder disease				
Depression or anxiety				
Eating disorder				
Migraine headache				
Seizures / epilepsy				
Glaucoma / cataracts				
Arthritis or joint / back pain				
Hepatitis / liver disease				
Anemia				
Blood transfusion				
Thyroid disease				
Other:				

Operations and/or Hospitalizations for Injuries or Illnesses		
Reason	**Date(s)**	**Hospital**

Name:

Medication allergies	☐ No ☐ Yes – please list medications & describe reactions	
	Med:	Reaction:
	Med:	Reaction:
Other allergies	☐ No ☐ Yes – please list allergens & describe reactions	

Review of Systems
Please indicate if you have any of the following symptoms

1.	Constitutional	☐ None	☐ Weight gain ☐ Weight loss	☐ Fever ☐ Fatigue	☐ Other:
2.	Eyes	☐ None	☐ Vision changes ☐ Glasses/contacts	☐ Other:	
3.	Ear, nose, throat	☐ None	☐ Headache ☐ Hearing loss	☐ Sinusitis ☐ Sore throat	☐ Other:
4.	Heart	☐ None	☐ Swelling ☐ Chest pain	☐ Palpitation ☐ Difficulty breathing on exertion	☐ Other:
5.	Lungs	☐ None	☐ Wheezing ☐ Cough	☐ Shortness of breath ☐ Other:	
6.	Stomach, intestines	☐ None	☐ Constipation ☐ Diarrhea	☐ Bloody stool ☐ Pain	☐ Nausea/indigestion ☐ Other:
7.	Vagina, bladder	☐ None	☐ Abnormal or painful periods ☐ Abnormal vaginal bleeding ☐ Abnormal vaginal discharge	☐ Painful intercourse ☐ Painful urination ☐ Frequent urination	☐ Leakage of urine ☐ Blood in urine ☐ Other:
8.	Muscles, bones	☐ None	☐ Muscle weakness ☐ Muscle or joint pain	☐ Other:	
9.	Skin	☐ None	☐ Rash ☐ Dry skin	☐ Worrisome moles	☐ Other:
10.	Breasts	☐ None	☐ Pain ☐ Lump(s)	☐ Nipple discharge ☐ Other:	
11.	Nerves	☐ None	☐ Memory problems ☐ Trouble walking	☐ Dizziness ☐ Numbness	☐ Other:
12.	Mood	☐ None	☐ Anxiety ☐ Depression	☐ Crying	☐ Other:
13.	Hormones	☐ None	☐ Hot flashes ☐ Hair loss	☐ Heat or cold intolerance ☐ Other:	
14.	Blood	☐ None	☐ Bleeding ☐ Bruising	☐ Swollen lymph node(s) ☐ Other:	

Name:

Family Medical History	
Mother	☐ Living ☐ Deceased, cause: Age:
Father	☐ Living ☐ Deceased, cause: Age:
Sisters	How many? ________ Ages:
Brothers	How many? ________ Ages:

Major Illness	Y	Which relative(s) and age of onset
Diabetes		
Stroke		
Heart disease		
Blood clots / lungs or legs		
High blood pressure		
High cholesterol		
Osteoporosis		
Hepatitis		
HIV / AIDS		
Tuberculosis		
Birth defects		
Drinking or drug problems		
Mental illness / depression		
Alzheimer's disease		
Other		

Thank you for completing this form.
We hope you have a successful first visit with us.

Reviewed by Clinician: ____________________________ Date: ________________