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Innovative Women's HealthCare Solutions
Patient *centered.* Patient *driven.* Patient *empowered.*

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New Patient to Practice Questionnaire

1. Name:_____ DOB: _____ Date: _____
2. Pharmacy Name & Location : _____ Phone: _____
3. Chief reason for today's visit: Annual Exam? □ Problem Visit? □ _____
4. First day of last menstrual period: _____
5. Date of last pap smear: _____Results: _____
6. Have you had a mammogram? **Y** **N** Date & result of last mammogram: _____
7. Bone Density Test? If yes, date: _____ Colonoscopy? If so, date: _____
8. Type of birth control currently using: _____
   - (including none, vasectomy, tubal ligation, condoms, withdrawal, IUD, abstinence, Oral Contraceptive Pill, Nuvaring, Nexplanon, female partner, or natural family planning methods)
9. Were you referred to our office? If so, please tell us by who. _____
10. Have you been diagnoses or treated for any of the following conditions: uterine fibroids, uterine polyps, endometriosis, ovarian cysts, PCOS, infertility, breast cyst/mass, other?

    _____
11. Are you interested in testing for Sexually Transmitted Infections today? Yes □ No □

OBSTETRICAL HISTORY

1. Are you currently pregnant? **Y** **N** If so, on what date was first positive pregnancy test? _____
2. How many pregnancies have you had? _____ How many miscarriages? _____ Abortions? _____
3. Please list **all** pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate if applicable.

Date	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery (vaginal, c-section, VBAC)	Complications (abortion, miscarriage, ectopic, early fetal demise)

GYNECOLOGICAL HISTORY

1. Age at first period: _____ How many days do your periods last? _____
2. How often do your periods come? □ Every 28-30 days □ More frequently □ Less frequently
3. How heavy is your menstrual flow? □ Light □ Moderate □ Heavy □ Extremely Heavy
4. Do you have bad cramps? **Y N** Do you have any PMS symptoms? **Y N**
5. Any bleeding between periods? **Y N** Any bleeding after intercourse? **Y N**
6. Any problems with urination (loss of urine while coughing, sneezing, etc.)? **Y N**

7. Check any of the following problems that you have had either in the past or currently:

□ Gonorrhea □ Pelvic Inflammatory Disease (PID) □ Herpes □ Vaginal Infections

□ IUD Related problems □ History of physical abuse, sexual abuse, domestic abuse? _____

□ Abnormal pap smears (what abnormality and when)? _____

MEDICAL HISTORY

1. Do you use medication on a regular basis, **including Medications/Supplements/Vitamins**? Please list name and dose of medication: _____

_____

2. Smoking History: Never smoker _____ Current smoker _____ Past smoker _____

   How much? _____ packs per day How many years?_____ When did you quit? _____
3. Do you drink alcohol? **Y N** How many alcoholic beverages do you have in a week? _____
4. Social drug use? **Y N** If so, what type of drugs do you use? _____
5. Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? _____
6. Have you ever been hospitalized for a medical illness? If so, please explain: _____

_____

7. Do you have any allergies to medications? **Y N** Do you have any other allergies? **Y N**

Please List: _____ Please list: _____

_____ _____

8. Do you have any history of a bleeding disorder? **Y N** Had a blood transfusion? **Y N**

9. What surgeries have you had? (please give year of surgery, including cosmetic):

Date	Procedure Type	Physician and/or location

SOCIAL HISTORY

Marital status: **M S D W P** Sexual Orientation? **Heterosexual** **Homosexual**

Occupation: _____ Religion: _____

FAMILY HISTORY (Please check if anyone in your family has any of these conditions)

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other relative
Cancer (type)									
Diabetes (type)									
DVT									
Heart Disease									
Osteoporosis									

REVIEW OF SYSTEMS- circle if you are having any of the following problems:

Skipping periods

Heavy vaginal bleeding

Bleeding between periods

Bleeding after menopause

Bleeding after intercourse

Anemia

Abnormal vaginal discharge

Vaginal odor

Recurrent vaginal infections

External genital itching

External genital lump/lesion

Pelvic pain

Painful periods

Painful intercourse

Pelvis mass

Difficulty getting pregnant

Urinary frequency

Urinary leakage

Pain with urination

Recurrent UTI

Blood in your urine

Pelvic pressure

Pelvic bulge or prolapse

Bothersome menopause symptoms

Significant hot flashes

Vaginal dryness

Breast pain

Breast mass

Nipple discharge

Chronic constipation

Chronic diarrhea

Persistent nausea or vomiting

Blood in your stools

Depressed mood

Increased anxiety

Irritability

Unexplained weight changes

Fever or chills