

New Patient - Gynecology History Questionnaire

Today's Date: _____

Patient Name: _____ Birth date: _____ Age: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Are we allowed to discuss your medical care with your emergency contact? Yes No

Do you wish to restrict access to your health information? **Yes** (see line below) **No**
If yes, please obtain a *Restriction Request Form* from the receptionist.

Referring Physician: _____ Primary Physician: _____

Past Medical History:

Please describe and provide the year of the occurrence.

Major illnesses and hospitalizations:

Operations:

Allergies:

Medications:

Personal history of the following conditions:

Yes	No	Unsure		Yes	No	Unsure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism				

Obstetric/Gynecological History:

Age at the time of your first period: _____

Number of pregnancies: _____ Number of children: _____ Cesarean section Yes No

Are you in menopause? Yes No If yes, at what age? _____ Are you on hormone therapy? Yes No

Beginning of last menstrual period: _____ Was it normal? Yes No

Last pelvic exam and Pap smear: _____ History of abnormal Pap smear? Yes No

Method of contraception: _____

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Patient Name _____ Account Number _____

Family History:

Yes No Unsure

- Heart disease
- Hypertension
- Stroke
- Diabetes
- Alcoholism
- Depression
- Suicide
- Other psychiatric illness
- Colon cancer
- Breast cancer
- Ovarian cancer
- Uterine cancer
- Osteoporosis

If yes, which family member(s)

Other:

Symptom Checklist:

1. General

Yes No Unsure

- Recent weight change
- Fever or chills or night sweats
- Dizziness or light-headedness
- Fainting
- Headaches
- Fatigue

2. Eye, ear, nose, and throat

- Glaucoma
- Blurred or double vision
- Hearing problems

3. Cardiovascular

- Palpitations
- Chest pain
- High cholesterol level
- Rheumatic fever
- Shortness of breath at night
- Difficulty breathing when lying flat
- Pain in legs with activity
- Blood clots

4. Respiratory

- Cough
- Sputum production
- History of pneumonia or pleurisy

5. Respiratory, continued

Yes No Unsure

- Shortness of breath with activity
- History of wheezing or asthma
- History of pulmonary emboli (blood clot to the lung)

6. Hematologic

- Personal or family history of easy bruising or bleeding
- Anemia
- History of blood transfusion

7. Gastrointestinal

- Abdominal pain
- Nausea or vomiting
- Bloating or food intolerance
- Ulcer disease
- Diarrhea
- Constipation
- Blood in stool
- History of binge eating, purging, or laxative use for weight control

8. Musculoskeletal

- Neck pain
- Back pain
- Joint problems
- Muscle weakness

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9. Neuropsychiatric

Yes No Unsure

- Seizures
- Tremor
- Difficulty with walking
- Memory loss
- Anxiety or stress
- Depression
- Difficulty sleeping
- Hospitalization for psychiatric problems

10. Genitourinary

- Pain or burning with urination
- Difficulty starting or holding urine
- Urinary or bladder infections
- Kidney or bladder infections
- Blood in the urine
- History of gonorrhea, chlamydia, or syphilis
- History of genital herpes
- History of genital warts
- HIV status tested. If yes, date last tested: _____

10. Genitourinary, continued

Yes No Unsure

- History of infertility
- Current sexual issues or problems
- History of sexual abuse
- Recent (within six months) exposure to sexually transmitted disease

11. Reproductive

- Possibly pregnant
- Change in menstrual pattern
- Unusual vaginal bleeding
- Pain with intercourse
- Vaginal itching or change in odor or color of discharge
- Other (describe) _____

12. Breasts

- Lumps
- Tenderness
- Drainage from nipple

Other History:

Family Status

- Single Married Significant Other Divorced Separated Widow(er)

Number of children _____ Minors _____ Adults _____

Occupation _____ Full time Part time Retired

Do you live alone? Yes No

If no, who do you live with? _____

Advance Directive

- Yes No Are you interested in more information about a Washington Durable Power of Attorney for Health Care or a Living Will?
- Yes No Do you currently have Washington Durable Power of Attorney for Health Care Living Will?
- Yes No Do we have a copy?
- Yes No Do you wish to make any changes?
- Yes No Do you have a legal guardian?

Diet

- Yes No Do you follow a special diet? If yes, what type? _____
- Yes No Have your eating habits changed recently? If yes, describe _____
- Yes No Have you had a recent weight change? If yes, how much? _____ Was it intentional? _____

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Habits

- Yes No Do you smoke? Cigarettes Pipe Cigar Chew How much? _____ How long? _____
- Yes No Did you smoke in the past? How much? _____ How long? _____
- Yes No Do you use alcohol?
- How much? 1-2 3-5 more than 5 drinks
- How often? Daily Weekly Monthly
- Yes No Do you use recreational drugs?
- If yes, Marijuana Cocaine Heroin Other

In the last year, have you felt you should cut down or stop:

- Drinking? Yes No Smoking? Yes No Using drugs? Yes No

Social and Coping Issues

- Yes No Do you have cultural or religious practices we should be aware of? _____
- Yes No Are you now or have you ever been in a relationship that causes you fear, pain, or injury?
If yes, describe _____
- Yes No Do you have good support from family or friends?

Communication

Are you able to:

- | | English | Other language _____ |
|------------|--|--|
| Read | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Speak | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Write | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Understand | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Functional Activities of Daily Living

Do you have problems sleeping? Yes No

Do you currently use any of the following (check all that apply)

- Glasses Wheelchair Contact lenses Cane Hearing aid
- Walker Crutches Dentures (upper, lower or partial?) _____
- Commode Braces (back, leg or arm?) _____
- Special bed Artificial eye Prosthesis (arm or leg?) _____ Other _____

Do you have difficulty completing any of the following activities alone?

- | | | | |
|--------------------------|--|---------------------|--|
| Bathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dressing/Undressing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Toileting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Walking 50 yards or more | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stair climbing | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you need help with the following?

- Taking medications Yes No
- Shopping Yes No
- Finances Yes No
- Telephone Yes No
- Preparing meals Yes No
- Transportation Yes No
- Laundry Yes No
- Housekeeping Yes No

Reviewed by _____ Date _____

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