

GYNECOLOGIC NEW PATIENT QUESTIONNAIRE  
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How did you hear about us? \_\_\_\_\_

Current Medications (Please list ALL medications including vitamins / herbals and the DOSES):

Medical History: (Please list ALL medical problems that you have now or in the past)

Allergies: (Please list ALL allergies to medicines / latex)

Gyn History: (Please list ANY gynecologic problems that you have now or in the past)

Are your periods regular?	Are you currently sexually active?
When was your last pap smear?	When was your last mammogram?
Have you ever had an abnormal pap smear?	Date last menstrual period started?
Have you ever had: Gonorrhea / Chlamydia / Herpes / Genital Warts / HPV	

OB History: (Please list ANY pregnancies that you have ever had including DATE/WEIGHT)

Surgical History: (Please list ANY surgeries that you have ever had and the YEAR)

Hospitalization: (Please list ANY hospital stays that you ever had and the reason/YEAR)

Family History: (Please list any medical problems that run in your family)

Cancer of uterus, breast, ovaries, colon?  
Heart attack or stroke < age 50?

Social History: (Please circle all those that you use currently or in the past)

\*Smoking (how many packs per day?). \*Recreational drug use. \*Exercise: yes/no. \*Alcohol.  
\*Sexually active: yes/no.

Review Of Systems:

Please CIRCLE all those symptoms that you have TODAY.

CONSTITUTIONAL

\* weight gain . \* loss of appetite . \* fever . \* weakness . \* formula feeding . \* weight loss .

\* night sweats . \* fatigue. \* chills.

#### DERMATOLOGY

\* rash . \* moles . \* lumps. \* dry or sensitive skin \* hives . \* acne . \* hair loss .

#### ENDOCRINOLOGY

\* fatigue. \* excessive thirst . \* excessive urination . \* weight loss . \* sleep disturbance .  
\* cold intolerance . \* heat intolerance. \* menopausal . \* hyperthyroid. \* hirsutism (excessive  
hair growth). \* acne . \* hypothyroidism. \* hair loss . \* night sweats .

#### NEUROLOGY

\* headache . \* tingling. \* seizures . \* insomnia (difficulty sleeping) . \* memory loss .  
\* dizziness . \* gait abnormality (difficulty walking) . \* numbness . \* Neuropathic pain  
(electric-type pain) . \* weakness .

#### OPHTHALMOLOGY

\* diminished vision . \* eye irritation . \* drainage from eyes . \* blurring of vision .  
\* seasonal eye symptoms . \* dander related eye symptoms . \* loss of vision .

#### RESPIRATORY

\* shortness of breath . \* chest pain . \* wheezing . \* congestion . \* cough.

#### ALLERGY

\* runny nose . \* itchy/watery eyes . \* ear fullness . \* sinus congestion .

#### HEMATOLOGY/LYMPH

\* fatigue. \* loss of appetite . \* varicose veins . \* easy bruising . \* anemia (low blood  
count).

#### UROLOGY

\* difficulty urinating. \* blood in urine . \* frequent urination. \* urinary incontinence (loss  
of urine). \* nocturia (urination at nighttime) . \* dysuria (painful urination) . \* urgency.

#### BREAST

\* Pain . \* Mass . \* Skin Changes . \* Discharge . \* Breast feeding .

#### OBSTETRIC

\* Contractions . \* Vaginal Bleeding . \* Leakage of fluid . \* Fetal movement yes/no

#### ENT

\* cold. \* cough. \* hearing loss . \* ringing in ears . \* sore throat .

#### CARDIOLOGY

\* chest pain . \* palpitations. \* leg swelling . \* dizziness . \* shortness of breath .  
\* varicose veins .

#### GASTROENTEROLOGY

\* nausea . \* heartburn. \* hemorrhoids . \* stomach upset, gastritis . \* Rectal pain . \* fecal  
incontinence (loss of stool) . \* vomiting. \* difficulty swallowing. \* abdominal pain .  
\* diarrhea . \* constipation. \* blood in stool.

#### MUSCULOSKELETAL

\* joint swelling. \* joint pain. \* leg cramps . \* joint stiffness . \* back pain .

#### PSYCHOLOGY

\* high stress level . \* depression . \* sleep disturbances . \* eating disorder . \* mental or  
physical abuse . \* mood swings . \* anxiety. \* Pressured speech .

#### FEMALE REPRODUCTIVE

\* heavy periods . \* dyspareunia (pain with sex) . \* sexually active yes/no . \* infertility.  
\* frequent yeast infections . \* pelvic pain . \* contraception yes/no . \* Regular periods yes/no .  
\* Irregular bleeding . \* amenorrhea (lack of periods) . \* vaginal dryness . \* decreased libido .

\* vaginal itching . \* dysmenorrhea (painful periods) . \* Vaginal / Perineal Lesions . \* vaginal  
odor. \* Sexual dysfunction . \* abnormal vaginal discharge . \* hot flashes .

