

Summit Women's New Patient Questionnaire

Date: _____ Your age: _____
Name: _____ Date of Birth: _____
Who is your PCP? _____
How did you hear about us? _____
Were you referred by a doctor? _____ If so, who? _____
What is your religious preference? _____

Gynecologic History:

Have you ever had: Ht: _____
 Gonorrhea? Y or N Wt: _____
 Chlamydia? Y or N BP: _____
 Genital herpes? Y or N Pulse: _____
 Genital warts? Y or N POX: _____
 Syphilis? Y or N Temp: _____
 Pelvic inflammatory disease? Y or N
Have you ever had an abnormal Pap smear? Y or N
 If yes, what type of treatment did you receive? _____
When was your last Pap smear? _____
Have you ever had a mammogram? Y or N
 If so, when was the last? _____
Have you ever been treated for infertility? Y or N
Have you ever been diagnosed or treated for
 Ovarian cysts? Y or N
 Fibroids? Y or N
 Endometriosis? Y or N
What is your sexual orientation? heterosexual bisexual homosexual
What are you using for birth control? _____
Have you used anything else in the past? Y or N
 If yes, what? _____
How old were you when you started your period? _____
Have you received Gardasil in the past? Y or N

If you have not gone through menopause answer this section:

When was your last period? _____
How often do your periods come? _____
How many days does your period last? _____
Is your flow light, moderate, or heavy? _____
Do you have pain with your periods? _____

If you have gone through menopause answer this section:

When did you stop having periods? _____

Have you ever been evaluated for bleeding after menopause? Y or N

Have you ever taken hormone replacement therapy? Y or N

Past Pregnancy History:

Date	Weeks at delivery	Weight	Sex	Route of delivery	Outcome or complications

Past Medical History:

Are you allergic to any medications? Y or N

If so, what and what reactions? Please list below:

Do you or did you have any of the following medical problems?

- Diabetes
- Hypertension
- Autoimmune disease
- Seizure disorder
- Hepatitis
- Migraines
- Thyroid dysfunction
- Asthma
- Kidney disease or frequent urinary tract infections
- Heart disease
- History of blood clots in your lungs or legs
- Psychiatric disorder
- AIDS
- Involved in a major accident
- Cancer
- Sickle cell disease or trait
- Anemia
- Bleeding disorder
- Other (please list)

Do you take any medications including over the counter or herbal medications? (please write below and include all vitamins):

Have you ever been hospitalized overnight? Y or N
What for?

Have you ever received a blood transfusion? Y or N

Have you ever had surgery? Y or N
Please list all surgeries and/or biopsies:

Social History:

Do you smoke? Y or N If yes, how much? _____

Do you drink alcohol? Y or N If yes, how much per week? _____

Do you use street drugs? Y or N If yes, what? _____

Are you: Single? Married? Divorced? Widowed?

Are you currently employed? Y or N
If yes, what do you do? _____

Have you ever been physically or sexually abused? Y or N

Are you safe at home? Y or N

Family History:

What is your race or ethnic background? _____

Does anyone in your family have any of the following?

- Neural tube defects
- Congenital heart defects
- Down syndrome
- Sickle cell disease or trait
- Thalassemia
- Hemophilia
- Tay-sachs
- Any birth defect or inherited problem?
- Muscular dystrophy
- Cystic fibrosis
- Mental retardation
- Hydrocephalus
- Neurological disorder (including seizures)
- Deafness or blindness
- Cleft lip or palate

Does anyone in your family have any of the following?

- Diabetes
- Hypertension/high blood pressure
- Autoimmune disease
- Blood clots
- Stroke
- Thyroid dysfunction
- Liver disease
- Asthma
- Kidney disease
- Heart disease
- Psychiatric disorder
- Cancer—if so, what type?
- Other medical conditions?

Review of systems:

Do you have any of the following?

- Weight loss
- Weight gain
- Fever
- Fatigue
- Vision changes
- Double vision
- Hearing problems
- Sore throat
- Chest pain/pressure
- Difficult/painful breathing
- Swelling of legs
- Shortness of breath
- Chronic cough
- Bloody stool
- Nausea/vomiting
- Frequent diarrhea
- Constipation
- Blood in urine
- Loss of urine
- Painful urination
- Muscle/joint pain
- Rash
- Trouble with walking
- Seizures
- Headaches
- Depression/crying spells

Is there any other information you would like to share that is not covered above? Please feel free to comment on what brings you here today.:
