NEW PATIENT HEALTH QUESTIONNAIRE

Name: _____ **Date**: _____

Reason for Today's Visit: _____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Significant Other

Number of Children: _____ Ages of Children: _____

Age at first period _____ Age at menopause (if applicable) _____

First Day of last menstrual period: _____

When was your last Pap test? (month and year): _____

Have you ever had an abnormal Pap test? ☐ YES ☐ NO

If yes, when and what treatment did you receive? _____

Are you sexually active? ☐ YES ☐ NO ☐ Not currently

If yes, is/are your partner(s): ☐ Male ☐ Female ☐ Both

Type of birth control/protection currently used:

☐ Not having sex (Abstinence) ☐ Condoms ☐ Injection ☐ Patch

☐ IUD (Intrauterine Device) ☐ Partner's vasectomy ☐ Pills (Brand) _____

☐ Tubal Ligation ☐ Other _____ ☐ NONE

CURRENT MEDICATIONS (INCLUDING SUPPLEMENTS AND HERBS)

Are you allergic to any medications? ☐YES ☐NO If yes, please list medication and reaction :

Do you have any chronic illnesses or major health problems? ☐ YES ☐ NO If yes, please list them

PAST SURGICAL HISTORY (Please list type and date of surgeries)

Review of Systems: Please circle any of the following you have now.

Skin: psoriasis ☐acne ☐eczema ☐dry skin ☐

Breast: implants ☐pain ☐lump ☐

Head: headaches ☐vision disturbance ☐hearing problem ☐dizziness ☐

Respiratory: cough ☐wheezing ☐shortness of breath ☐

Cardiac: heart racing ☐skipping beats ☐high blood pressure ☐

GI: nausea ☐vomiting ☐ reflux ☐diarrhea ☐constipation ☐hemorrhoids ☐

GYN: irregular periods ☐ heavy bleeding ☐cramps ☐pain with sex ☐spotting between periods ☐
bleeding after sex ☐hot flashes ☐night sweats ☐vaginal dryness ☐

History of sexually transmitted disease ☐

GU: stress incontinence ☐urgency ☐ getting up at night to void ☐ frequency ☐ burning ☐

Musculo-skeletal: muscle aches ☐ leg cramps ☐arthritis ☐ joint pain ☐

Endocrine: thyroid ☐ diabetes ☐ polycystic ovarian syndrome ☐ galactorrhea ☐

Have you ever had a mammogram? ☐ YES ☐ NO When was your last one? _____

Have you ever had a bone density test? ☐ YES ☐ NO When was your last one? _____

Have you ever had a colonoscopy? ☐ Yes ☐ NO When was your last one? _____

FAMILY HISTORY

Has anyone in your family ever had: (List the relative and age at diagnosis)

Cancer? ☐ YES ☐ NO _____

Diabetes? ☐ YES ☐ NO _____

Hypertension? ☐ YES ☐ NO _____

Heart Disease? ☐ YES ☐ NO _____

Epilepsy? ☐ YES ☐ NO _____

Birth Defects? ☐ YES ☐ NO _____

Problems with Anesthesia? ☐ YES ☐ NO _____

SOCIAL HISTORY

Occupation _____

Full time ☐ Part time ☐ Retired ☐

Education: High School ☐ 2 year college ☐ 4 year college ☐ Post graduate ☐

Alcohol use. Do you drink alcohol? ☐ YES ☐ NO How many drinks per week? _____

Tobacco use. Do you use tobacco? ☐ YES ☐ NO How many cigarettes do you smoke a day? _____

If not currently, did you ever use tobacco? ☐ YES ☐ NO #of years____ Year quit_____

Do you need help to quit? ☐ YES ☐ NO

Drugs use. Do you currently use recreational or street drugs? ☐ YES ☐ NO

Caffeine use. None ☐ Occasional ☐ Moderate ☐ Heavy ☐ # of cups/cans per day ____

Exercise Level: None ☐ Occasional ☐ Moderate ☐ High level ☐ How often? _____

How much calcium (servings or milligrams) do you get in a day? _____

Have you ever been or are you currently being abused physically, emotionally, or sexually? ☐ YES ☐ NO

Are you afraid of your spouse/partner/significant other? ☐ YES ☐ NO

Would you like to be tested today for sexually transmitted disease? ☐ YES ☐ NO

For patients under the age of 26:

Have you had the Gardasil Vaccine? ☐ YES ☐ NO

If no, would you like to get the vaccine? ☐ YES ☐ NO

PATIENT SIGNATURE: _____