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: ____