NEW PATIENT QUESTIONAIRE

NAME: ____DATE: ____
Age _____ Race _________ Married ( ) Single ( ) Divorced ( ) Widowed ( )
Drug Allergies ____

Last menstrual Period _______________ Cycles Regular ( ) Irregular ( )
At what age did you started your first period? _________ Age at First birth ___________________
Last Pap smear __________ Have you had any abnormal pap smears in the past? YES NO
Last Mammogram __________ Have you had any abnormal mammogram? YES NO
Surgeries: Year ______ Description ____
Year ______ Description ____
Year ______ Description ____
Hospitalizations (other than surgeries):
Year ______ Description ____
Year ______ Description ____
Medications ______________________ Dose ___________ How long? ______________________________________
______________________ Dose ___________ How long? ______________________________________
______________________ Dose ___________ How long? ______________________________________
Contraception ____ How long? ________________________________
Cigarettes _______per day Alcohol _____________Drug use ____
PREGNANCIES:

Year	Hospital	City/ State	Type of delivery	Complications

FAMILY HISTORY:

	Age	Living	Deceased	Health or cause of death
FATHER				
MOTHER				
SIBLINGS				

CIRCLE IF ANY BLOOD RELATIVES HAS HAD:
Heart disease Kidney disease Tuberculosis Mental disorder
High blood pressure Diabetes Cancer Seizures

YOUR PAST MEDICAL HISTORY

Circle if you have had any of the following:

Pelvic Infection
Mental Disorder
Arthritis
Rheumatic Fever
Varicose Veins
Pneumonia
Hepatitis
Ulcers
Asthma
Cancer

Diabetes
Thyroid Disease
Heart Disease
Drugs
Phlebitis
Heart Murmur
Seizures
Kidney Disease
Kidney Infection

Sexually Transmitted Disease
Liver or Gall Bladder Disease
High Blood Pressure
Breast Discharge o Mass
Blood Disorder
Blood Transfusion
Broken Bones
Sinus Headaches
Migraine Headaches