



OBSTETRICS AND GYNECOLOGY

New Patient Questionnaire

All information will be reviewed by your practitioner and kept confidential. If you don't understand a question, leave it blank and your healthcare team will assist you.

Name:

Date of Birth:

Age:

Today's Date:

Primary care provider:

Who referred you for this visit?

Reason for visit:

How did you hear about us?

Menstrual History

Last menstrual period began _____

My periods are Regular Irregular Heavy Normal Painful
 Manageable/tolerable Unmanageable, I want to talk about treatment options
 Other problems _____

Method of contraception:

None Tubal ligation Partner had vasectomy Hormones (pill, patch, or ring)
 Condoms IUD Other _____

I went through menopause at age _____

I am currently using hormones.
 I have used hormones in the past, and quit in _____
 I have had spotting or bleeding since menopause.

Sexual History

I am in a heterosexual relationship with my husband/significant other
 I am in a same sex relationship
 I am not currently sexually active
 I have never been sexually active

Over

Pregnancy History

Number of pregnancies _____ Number of live births _____ Number of premature births _____
 Number of abortions _____ Number of miscarriages _____ Number of living children _____

#	Yr. / Mo. of birth	Birth weight	Gender	Wks. Preg.	Type of delivery	Complications
1	/	Lb. oz.	M F			
2	/	Lb. oz.	M F			
3	/	Lb. oz.	M F			
4	/	Lb. oz.	M F			
5	/	Lb. oz.	M F			
6	/	Lb. oz.	M F			
7	/	Lb. oz.	M F			

Medical History

Do you have or have you had any of the following? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Breast problems
<input type="checkbox"/> Heavy / Irregular uterine bleeding
<input type="checkbox"/> Uterine fibroids
<input type="checkbox"/> Abnormal pap smears / HPV
<input type="checkbox"/> Pelvic infection
<input type="checkbox"/> Herpes
<input type="checkbox"/> Vulvar problems
<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Depression / Mental illness
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Stroke
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Heart disease / Murmur
<input type="checkbox"/> Blood clot in leg or lungs | <input type="checkbox"/> Lung problems (asthma, COPD)
<input type="checkbox"/> Stomach problems (Ulcer, GERD, etc.)
<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Gallbladder disease
<input type="checkbox"/> Colon problems (Diverticulitis, Colitis, Crohn's,)
<input type="checkbox"/> Hepatitis / Liver disease
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Collagen vascular disease (Lupus)
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Previous bone fractures
<input type="checkbox"/> Osteopenia / Osteoporosis
<input type="checkbox"/> Back problems
<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Cancer
<input type="checkbox"/> Other serious illness (please describe)
_____ |
|--|--|

Surgical History / Hospitalizations

Please list any surgeries or hospitalizations.

Surgery / Hospitalization	Year	Surgery / Hospitalization	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

If you check any of the following, please indicate relationship.

<u>Problem</u>	<u>Relationship</u>	<u>Problem</u>	<u>Relationship</u>
<input type="checkbox"/> Breast cancer	_____	<input type="checkbox"/> High cholesterol	_____
<input type="checkbox"/> Ovarian cancer	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Uterine cancer	_____	<input type="checkbox"/> Emotional / mental issues	_____
<input type="checkbox"/> Colon cancer	_____	<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Birth defects	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Heart disease	_____		

Social History

Please tell us about yourself. This information is intended to help us understand and meet the varied needs of the women we see at Mid-Michigan Physicians OB / GYN.

1. Are You?

single, never married married divorced widowed other

2. Please choose the one that best describes your household:

live alone live with partner/Husband live with parents
 single parent, living with children live with partner and children live in school dorm
 live with same sex partner blended family / step children
 live in a supervised living setting currently homeless or living in a shelter

3. Do you? (check all that apply)

work as mother / homemaker attend school work outside the home as _____
 other

Smoking.

Do you smoke?

Never Currently _____ pack per day for _____ years Interested in quitting
 Smoked for _____ years and quit in _____

Alcohol / Drug use.

Do you drink alcohol?

Never Drink socially In recovery Interested in quitting or cutting down

Do you use drugs?

Never Yes – type? _____ In recovery Interested in quitting or cutting down.

Over

Prevention

Immunizations – Please give date (year) of last immunization

Flu shot _____	Measles / Mumps / Rubella _____	Chicken Pox _____
Tetanus / Diphtheria _____	Hepatitis B _____	Pneumovax _____
Gardasil / HPV _____		

Health Maintenance – please give dates (year) of most recent

Dental visit _____	Vision testing _____	Mammogram _____
Bone density _____	Colonoscopy _____	Cholesterol _____
Pap smear _____		

Safety.

<u>YES</u>	<u>NO</u>	
<input type="checkbox"/>	<input type="checkbox"/>	I always use seatbelts.
<input type="checkbox"/>	<input type="checkbox"/>	I have smoke detectors in my home.
<input type="checkbox"/>	<input type="checkbox"/>	I feel safe in my home
<input type="checkbox"/>	<input type="checkbox"/>	I feel safe at work / school
<input type="checkbox"/>	<input type="checkbox"/>	I have recently been hit, slapped, kicked, or otherwise physically hurt by someone.
<input type="checkbox"/>	<input type="checkbox"/>	I have recently been forced to engage in sexual activities against my will.

Review Of Systems

Have you been experiencing any of the following problems?

<input type="checkbox"/> Headaches	<input type="checkbox"/> Nausea / Vomiting
<input type="checkbox"/> Visual changes	<input type="checkbox"/> Constipation
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Cough / Wheeze	<input type="checkbox"/> Blood in stools
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Frequency, urgency or pain with urination
<input type="checkbox"/> Weight changes	<input type="checkbox"/> Leaking of urine
<input type="checkbox"/> Fevers	<input type="checkbox"/> Vulvovaginal pain, itching, rash, or discharge
<input type="checkbox"/> Felt lump in breast	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> NONE
<input type="checkbox"/> Depression	
<input type="checkbox"/> Muscle/joint pain or weakness	
<input type="checkbox"/> Increased thirst	