NORTHWEST WOMEN'S HEALTHCARE

New Patient Questionnaire

Name: _____ Date Of Appt: _____

Age: _____ Birth Date: _____ Pharmacy: _____

Preferred Pronouns: _____ PCP: _____

Occupation: _____ Referred By: _____

Reason for Visit: _____

DO YOU HAVE ANY QUESTIONS OR CONCERNS TODAY?

GYNECOLOGIC HISTORY

Onset of last period: _____

Age at first period: _____

How many days do you bleed? _____

Length of cycles (days between periods): _____

Are your periods painful? ☐ yes ☐ no

Any bleeding between periods? ☐ yes ☐ no

Any bleeding after intercourse? ☐ yes ☐ no

Any vaginal itching or abnormal discharge? ☐ yes ☐ no

Any history of recurrent ☐ Bacterial vaginosis ☐ Yeast

If you are menopausal

At what age did you stop menstruating? _____

Have you ever taken hormones? ☐ yes ☐ no

Are you taking hormones now? ☐ yes ☐ no

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HEALTH CARE MAINTENANCE

Date of last pap smear ___/___/_____

Result? ☐ Normal ☐ Abnormal

If abnormal, please list treatment/date: _____

Have you ever had (mark if yes):

☐ Cryotherapy ☐ Biopsy ☐ Laser ☐ LEEP

☐ Human Papillomavirus (HPV) ☐ The HPV vaccine

An abnormal pap? ☐ yes ☐ no If yes, when? ___/___/_____

Mammogram? ☐ yes ☐ no If yes, when? ___/___/_____

Colonoscopy? ☐ yes ☐ no If yes, when? ___/___/_____

DEXA bone scan? ☐ yes ☐ no If yes, when? ___/___/_____

When did you last have your cholesterol checked? ___/___/_____

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SEXUAL HISTORY

Are you sexually active? ☐ yes ☐ no

If yes, with: ☐ men ☐ women

☐ oral ☐ genital ☐ anal ☐ other

Have you ever had an STD? ☐ yes ☐ no

If yes: ☐ Herpes (oral/genital) ☐ Gonorrhea ☐ HPV

☐ Chlamydia ☐ Syphilis ☐ HIV

Would you like an STD screen today? ☐ yes ☐ no

Number of partners in the last 5 years: ☐ 0 ☐ 1 ☐ 2-5 ☐ >5

Do you currently use birth control? ☐ yes ☐ no

What do you use?

Are you satisfied with this method? ☐ yes ☐ no

Are you currently trying to get pregnant? ☐ yes ☐ no

If yes, for how long have you been trying?

What have you used for birth control in the past?

☐ Condoms ☐ IUD ☐ Pill ☐ Nuvaring

☐ Implant ☐ Patch ☐ Diaphragm

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OBSTETRICAL HISTORY

☐ check here if never pregnant

Are you currently pregnant? ☐ yes ☐ no

Have you had infertility treatment? ☐ yes ☐ no

If so, where? _____

Please describe: _____

#	DATE	PREGNANCY OUTCOME (MISCARRIAGE, VAG DEL, C/S)	LENGTH (WKS)	EPIDURAL?	GENDER	WEIGHT	HOSPITAL	COMPLICATIONS?
1								
2								
3								
4								
5								

UROLOGIC HISTORY

Do you lose urine with cough/sneeze? ☐ yes ☐ no

Do you have a history of bladder infections? ☐ yes ☐ no

History of kidney infections? ☐ yes ☐ no

SURGICAL HISTORY

Year	Surgical Procedure

MEDICAL HISTORY

YES	NO	HAVE YOU EVER HAD:
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorder
☐	☐	Migraine headaches with aura
☐	☐	Thyroid disorder
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	Heart disease
☐	☐	Echocardiogram
☐	☐	Breast lump evaluated
☐	☐	Asthma
☐	☐	Deep Vein Thrombosis (DVT)
☐	☐	Pulmonary Embolism (PE)
☐	☐	Stomach ulcers
☐	☐	Intestinal problems
☐	☐	Gallstones
☐	☐	Diabetes
☐	☐	Kidney problems
☐	☐	Liver problems/hepatitis
☐	☐	Blood transfusion
☐	☐	Cancer
☐	☐	Autoimmune disorder
☐	☐	Osteoporosis

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Other Medical History: _____

FAMILY HISTORY

HAVE ANY RELATIVES HAD:	YES	NO	IF YES, WHO?
Breast cancer	☐	☐	
Ovarian cancer	☐	☐	
Colon cancer	☐	☐	
Heart attack	☐	☐	
Stroke	☐	☐	
High blood pressure	☐	☐	
Diabetes	☐	☐	
Birth defects	☐	☐	
Reaction to anesthesia	☐	☐	
Kidney disease	☐	☐	
Liver disease	☐	☐	

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Other conditions: _____

SOCIAL HISTORY

Are you: ☐ Single ☐ In a relationship ☐ Married ☐ Partnered ☐ Divorced ☐ Other

SOCIAL HISTORY (CON'T)

DO YOU:	YES	NO
Smoke tobacco products?	☐	☐
Drink alcohol?	☐	☐
How many drinks per week? ☐ 0 ☐ 1-5 ☐ 5-10 ☐ >10		
Use Marijuana?	☐	☐
Use other recreational drugs?	☐	☐
Suffer ongoing abuse or trauma?	☐	☐
Feel safe?	☐	☐
Wear your seatbelt?	☐	☐
Exercise regularly?	☐	☐
Have guns in the home?	☐	☐
If so, are they secured?	☐	☐

Religious preference: _____

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REVIEW OF SYSTEMS

Do you currently have any of the following symptoms?

- ☐ Body aches
- ☐ Fatigue
- ☐ Night sweats
- ☐ Impaired vision
- ☐ Headaches
- ☐ Breast lumps
- ☐ Nipple tenderness or discharge
- ☐ Chest pain
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Urinary incontinence
- ☐ Pain with urination
- ☐ Skin rash
- ☐ Numbness
- ☐ Joint pain
- ☐ Heat/cold intolerance
- ☐ Depression
- ☐ Anxiety
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Seasonal allergiesAnxiety
- ☐ Easy bleeding/bruising
- ☐ Seasonal allergies

MEDICATIONS

Please list current medications, doses, instructions (include vitamins and supplements)

MEDICATION	DOSE	FREQUENCY

Medication allergies (and reaction)

ANYTHING ELSE WE SHOULD KNOW TO HELP US IN YOUR CARE?

PATIENT SIGNATURE: _____ **DATE:** _____