

**New Patient Questionnaire  
General Gynecology**

**Fertility & Women's Health Center of Louisiana**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

---

**Preventive Medicine:**

1. When was your last mammogram? \_\_\_\_\_
2. Have you ever had an abnormal mammogram? YES NO
3. When was your last pap smear? \_\_\_\_\_
4. Have you ever had an abnormal pap smear? YES NO
5. Have you ever had a colonoscopy? YES NO
6. Have you ever had a bone scan (test for osteoporosis)? YES NO

**Obstetric History:**

1. Have you ever been pregnant YES NO  
If yes, # of pregnancies \_\_\_\_\_ # of term vaginal deliveries \_\_\_\_\_  
# of miscarriages \_\_\_\_\_ # of elective terminations \_\_\_\_\_  
# of C-sections \_\_\_\_\_ # of ectopic (tubal pregnancies) \_\_\_\_\_

Type of treatment: SURGERY MEDICATION

**Gynecologic History:**

1. At what age did you have your first period? \_\_\_\_\_
2. What is your average menstrual cycle length (28 days)? \_\_\_\_\_
3. How many days do you usually bleed? \_\_\_\_\_
4. Are your periods regular? YES NO
5. Are your periods: HEAVY LIGHT MODERATE
6. Do you have premenstrual breast tenderness and/or uterine cramps? YES NO
7. My menstrual pain is: MINIMAL SEVERE MODERATE
8. Have you ever had any sexually transmitted disease? YES NO  
If yes, please circle those that apply: CHLAMYDIA GONORRHEA  
SYPHILIS VENEREAL WARTS HERPES TRICHOMONAS  
HIV PELVIC INFLAMMATORY DISEASE (PID)
9. Have you ever been diagnosed with ENDMETRIOSIS? YES NO  
If yes, what stage? \_\_\_\_\_
10. Have you ever used an IUD? YES NO

**Gynecologic History Cont:**

- 11. Did your mother use DES to prevent miscarriage while pregnant with you?  
YES                      NO                      UNSURE
- 12. Have you ever had a D&C (procedure used with miscarriage, abortion or a uterine bleeding problem)?    YES, when? \_\_\_\_\_
- 13. Have you ever had an abnormal pap smear    YES                      NO  
If yes, any treatment for abnormal pap smear? \_\_\_\_\_

**For Menopausal Patients:**

- 1. Do you experience any of the following symptoms? How often?
  - a. Hot flashes \_\_\_\_\_per week
  - b. Mood swings \_\_\_\_\_per week
  - c. Unexplained irritability:    Always                      Sometimes                      Never
  - d. Vaginal dryness:    Always                      Sometimes                      Never
  - e. Decreased libido (sex drive):    Always                      Sometimes                      Never
  - f. Excessive hair growth:    YES                      NO
  - g. Weight gain \_\_\_\_\_pounds in the last 6 months
- 2. Have you ever tried hormone replacement therapy?    YES                      NO  
What type and for how long? \_\_\_\_\_  
\_\_\_\_\_
- 3. Do you take alternatives to hormone replacement treatments?    YES                      NO  
What type and for how long? \_\_\_\_\_  
\_\_\_\_\_
- 4. Do you take calcium regularly?    YES                      NO
- 5. How many glasses of milk do you drink per day? \_\_\_\_\_

**General Medical History:**

- 1. Have you had a significant weight loss/gain in the past year?    Loss                      Gain  
If yes, how many pounds? \_\_\_\_\_
- 2. Have you been unusually **tired** recently?    YES                      NO
- 3. Have you noticed any **milky discharge** from your breast?    YES                      NO
- 4. Have you had any increased or unusual **acne** recently?    YES                      NO
- 5. Have you noticed any **hair growth** on your face or breast?    YES                      NO
- 6. Do you have any other medical problems or conditions?    YES                      NO  
If yes, please describe condition and treatment, including medications you are taking:  
\_\_\_\_\_  
\_\_\_\_\_
- 7. Please list your previous surgeries, including what type and when: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8. Please list all medication you are currently taking (include all vitamins and herbal medicines, prescribed and over-the-counter), including dosage and frequency:  
\_\_\_\_\_  
\_\_\_\_\_

**General Medical History Con't:**

- |   |     |    |
|---|-----|----|
| 9. Are you allergic to any medications? | YES | NO |
| 10. Do you smoke?                       | YES | NO |
| 11. Do you drink alcohol?               | YES | NO |
| 12. Do you use illicit drugs?           | YES | NO |
- If yes, what type? \_\_\_\_\_

PLEASE TAKE A MOMENT TO LIST ANY OTHER QUESTIONS OR CONCERNS YOU MIGHT HAVE REGARDING YOUR GENERAL HEALTH:

---

---

---

---

---

---

---

---