

Fertility & Women's Health Center of Louisiana

New Patient Questionnaire General Gynecology

NAME: _____

Age: _____ DOB: _____

17. Have you ever had an abnormal pap smear?

YES NO

If yes, what treatment did you have? _____

GYNECOLOGIC HISTORY

1. What is the main reason for your visit today?

2. At what age did you have your first period?

3. What is your average menstrual cycle length (28 days)? _____
4. How many days do you usually bleed?

5. Are your periods regular? YES NO
6. How would you describe your periods?
HEAVY LIGHT MODERATE
7. Do you have premenstrual breast tenderness and/or uterine cramping? YES NO
8. How would you describe your menstrual pain?
MINIMAL MODERATE SEVERE
9. Have you ever been treated for:

	Y	N	Dates
Syphilis			_____
Gonorrhea			_____
Chlamydia			_____
Genital warts			_____
PID			_____
HIV/AIDS			_____
10. Have you ever been diagnosed with ENDOMETRIOSIS? YES NO
If yes, what stage? _____
11. Have you ever used an IUD? YES NO
12. Do you experience pain with intercourse?
YES NO
13. Do you experience pain with bowel movements?
YES NO
14. Have you ever been treated for infertility?
YES NO
15. Do you experience pain with urination?
YES NO
16. Have you ever had a D&C (procedure used with miscarriage, abortion or a uterine bleeding problem)?
YES NO
If yes, when? _____

PREGNANCY HISTORY

How many times have you been pregnant? _____

Please detail each pregnancy using the chart below:

	Ending Mo/Yr	How long to conceive?	Infertility treatment?	Term/Preterm/Miscarriage/Ectopic/Abortion	Vaginal/Cesarean	Problems or Complications with pregnancy, delivery or childhood?
1 st						
2 nd						
3 rd						
4 th						
5 th						
6 th						

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 increase in 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: _____

9. Are you allergic to any medication?
 YES NO
 If yes, please list: _____

10. Do you smoke?
 YES NO
 If yes, how many packs per day? _____
11. Do you drink alcohol?
 YES NO
 If yes, how many times per week?

12. Do you use illicit drugs?
 YES NO
 If yes, what types and how often/

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

FOR MENOPAUSAL PATIENTS

1. Do you experience any of the following symptoms:
 - a. Hot flashes _____ times per week
 - b. Mood swings _____ times 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 6mths

2. Have you ever tried hormone replacement therapy (HRT)?
 YES NO
 If yes, what type and for how long? _____
3. Do you take alternatives to hormone replacement treatments?
 YES NO
 If yes, 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?

FAMILY MEDICAL HISTORY

1. Does anyone in your family have:

a. Diabetes	YES	NO
b. Stroke	YES	NO
c. Heart Disease	YES	NO
d. High Blood Pressure	YES	NO
e. Alcoholism	YES	NO
f. Breast Cancer	YES	NO
g. Ovarian Cancer	YES	NO
h. Colon Cancer	YES	NO

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 (to test for osteoporosis)?
 YES NO