585 E.Elder St.
Fallbrook CA 92028
760-645-3407

GYNECOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name____ Date of Birth_____/_____/__________

Today's Date_____/_____/__________

PAST MEDICAL & FAMILY HISTORY Please check (✓) if you (SELF) or any blood relative (FAM) had any of the following conditions.

	SELF	FAM	EXPLAIN		SELF	FAM	EXPLAIN
Headaches	❑	❑		Blood Transfusions	❑	❑	
Heart / Vascular Disease	❑	❑		Anemia / Blood Disorder	❑	❑	
Rheumatic Disease	❑	❑		Stroke	❑	❑	
High Blood Pressure	❑	❑		DVT / Pulmonary Embolism	❑	❑	
High Cholesterol	❑	❑		Skin Disease	❑	❑	
Respiratory Disease	❑	❑		Diabetes	❑	❑	
Pulmonary (Lung) / Asthma	❑	❑		Thyroid Disease	❑	❑	
Breast Cancer	❑	❑		Cancer (Type)	❑	❑	
Jaundice / Hepatitis	❑	❑		Uterine or Ovarian Cancer	❑	❑	
Reflux / Ulcer	❑	❑		Epilepsy / Neurological Disease	❑	❑	
Bowel Disease / Colon Cancer	❑	❑		Arthritis - Joint Pain	❑	❑	
Kidney Disease	❑	❑		Osteoporosis / Joint Problems	❑	❑	
Urinary Incontinence	❑	❑		Anxiety / Depression	❑	❑	
Urinary Infections	❑	❑		Sleep Problems	❑	❑	
STD	❑	Partner? ❑					

DRUG ALLERGIES?

VACCINES Chicken Pox ❑ Childhood Vaccines ❑ HPV ❑ Hepatitis A ❑ Hepatitis B ❑ Last Tetanus ____________________

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PAST MEDICAL HISTORY

PAST SURGICAL HISTORY Give the year of the procedure and explain

MEDICATIONS List all medications you are currently taking.	**ALLERGIES & REACTIONS**

MENSTRUAL HISTORY Age at first period? _______ 1st day last period? ____/____/____ Cycle length? _______
Duration of bleeding? _______ Cramps? Y ❑ N ❑ If yes: Mild ❑ Moderate ❑ Severe ❑ Always Present ❑
Bleeding? Light ❑ Moderate ❑ Heavy ❑
Hot Flashes? Y ❑ N ❑ If yes, treatment ____

PAP Last test ____/____/____ Ever had abnormal result? Y❑ N ❑ **MAMMOGRAM** Last test ____/____/____ Ever had abnormal result? Y ❑ N ❑

CONTRACEPTION Current Method _________________ **ARE YOU CONSIDERING GETTING PREGNANT IN THE FUTURE?** Y❑ N ❑

OBSTETRICAL HISTORY # of Pregnancies _____ Premature Babies _____ Miscarriages _____ Abortions _____
Living Children ______

	BIRTH DATE	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS		BIRTH DATE	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS
1							4						
2							5						
3							6						

SOCIAL HISTORY Smoking - Cig./Day _____ # Years _____ Alcohol - Oz./Week ______ Caffeine - Cups/Day ______
Street Drugs ________________