New Patient Questionnaire
Capital Women's Care Division 66

DEMOGRAPHICS

Name ____ Date________________
Date of Birth ___________ Age____ Primary Care Provider _________________

WELL WOMAN UPDATE (PLEASE PROVIDE DATES WHERE APPLICABLE)

Last bone density exam ________________(year)
Last colonoscopy ______________________(year)
Last mammogram ______________________(year)
Last Pap smear __________________(month/year)

Last tetanus shot _____________(year)
HPV/ Gardasil Vaccine series completed? ___ YES __ NO
Have you had the Hepatitis B series? ___ YES __ NO

Any abnormal Pap smears? _____YES____NO
Cervical Dysplasia (precancerous cells of the cervix)? _____YES____NO
If yes, any treatment? Dates:
LEEP ___________________________
Laser ___________________________
Cryo (freezing) ___________________________
Cone Biopsy ___________________________

MEDICAL HISTORY (PLEASE SELECT ALL THAT APPLY)

- ☐ Asthma
- ☐ Autoimmune disorder ______________________
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer (type?) __________
- ☐ Chicken pox
- ☐ Chicken pox vaccination
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Elevated cholesterol
- ☐ Endometriosis
- ☐ Fibroids (type?)__________
- ☐ GERD/Reflux
- ☐ G.I. illness ______________
- ☐ Gestational Diabetes
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ HIV
- ☐ HPV/genital warts
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pelvic inflamm. disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis

Other: ____

Surgical History: Please list ALL surgical procedures, including year:

____
____
____
____
____
____

Anesthesia Complications: Please check those that apply.

- ☐ Excessive difficulty waking up
- ☐ Malignant Hyperthermia
- ☐ Difficult intubation

Medicines & Allergies:

Current medications & dosage ____________________________
____
Vitamins/ herbal supplements ____________________________
Drug allergies ____________________________________
Reaction ______________________________________

FAMILY HISTORY (Specifically, do you have any family members with breast cancer, ovarian cancer, uterine cancer, colon cancer?)

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

REPRODUCTIVE HISTORY

Age at first period? ______ If menopausal, age of menopause: _______

How often do you get your menstrual cycle? Every _____ days, lasting ____ days.

Are your cycles? ☐ Regular ☐ Irregular

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Method of contraception:

☐ Not Needed ☐ Vasectomy ☐ Rhythm Method ☐ Implanon ☐ Tubal Ligation

☐ None ☐ Condoms ☐ NuvaRing ☐ Mirena IUD ☐ Essure

☐ Pill ☐ Patch ☐ Depo Provera ☐ ParaGuard IUD ☐ Other_____________

OBSTETRIC HISTORY

Year	Weeks	Labor Length	Birth Wt LB. / OZ.	Sex	Type Of Delivery	Type of Anesthesia	Hospital/ Location	Complications
Example: 2/2/2008	*38 wks*	*14 hours*	*6lbs8oz*	*M*	*Vacuum*	*Epidural*	*Gwinett Medical Center, GA*	*Diabetes, low amniotic fluid*

SOCIAL HISTORY

Occupation:____

Are you? ☐ Married ☐ Single ☐ Engaged ☐ Significant other ☐ Divorced ☐ Widowed ☐ Same Sex Partner

Significant other's name: ______________________________Phone#______________________

Other emergency contact name: __________________________Phone # ____________________

Tobacco Use: ☐ Never ☐ Current___ # of Cigarettes per day ☐ Former, Quit at age _____

Any alcohol use? YES NO *If yes, the average number of drinks per week ___________

Do you use street drugs? YES NO *If yes, the type used and last use ____________________

How many times and how long per week do you exercise? (circle) 1X 2X 3X 4X 5X+

Per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? ☐ Daily ☐ Some ☐ No

Any history of violence or abuse in your current household or in your past? ______NO______YES

Do you have any cultural or religious considerations that need special attention? ______NO______YES

GENETIC SCREENING (*FOR NEW OBSTETRIC PATIENTS ONLY*, CHECK YES OR NO FOR EACH CONDITIONS BELOW)

NO	YES	Includes patient, baby's father, or anyone in either family with:
		Patient's age 35 years or older as of estimated date of delivery
		Thalassemia (Italian, Greek, Mediterranean or Asian Background)
		Neural tube defect (Meningomyelocele, spina bifida, anencephaly)
		Congenital heart defect
		Down Syndrome
		Tay-Sachs (Ashkenazi Jewish, Cajun, French Canadian)
		Canavan Disease (Ashkenazi Jewish)
		Familial Dysautonomia (Ashkenazi Jewish)
		Sickle Cell disease or Trait (African)
		Hemophilia or other blood disorder
		Muscular Dystrophy
		Cystic fibrosis
		Huntington's Chorea
		Mental Retardation/Autism
		Other inherited genetic or chromosomal disorder
		Maternal Metabolic disorder (E.g. Type I Diabetes, PKU)
		Patient or baby's father had a child with birth defects
		Recurrent pregnancy loss or a stillbirth
		Medications (including supplements, vitamins, herbs, recreational drugs/alcohol since LMP (If yes, please list agents:)

Patient Signature: ____ Date: ____________