

THE WOMEN'S GROUP OF GWINNETT, P.C.

New Patient Gynecology Questionnaire

NAME: _____

DATE: _____

DATE OF BIRTH: _____

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) _____

PAST MEDICAL HISTORY:

List all operations you have had.

List all illnesses you have had that required hospitalization.

	OPERATION	DATE
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____
E.	_____	_____

	ILLNESS	DATE
A.	_____	_____
B.	_____	_____
C.	_____	_____
D.	_____	_____
E.	_____	_____

Have you ever had? (Check yes or no and give dates.)

Please list any additional medical conditions or illnesses.

YES	NO	ILLNESS	DATE	YES	NO	ILLNESS	DATE	ILLNESS	DATE
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	_____	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice of Hepatitis	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	_____	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	_____	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	German Measles or Vaccine	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or Seizures	_____	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	_____	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	I will accept blood products if necessary	_____						

REVIEW OF SYSTEMS:

Are you currently having or have you recently had any of these symptoms? (Check "Yes" or "No")

	A. GENERAL		B. CHEST AND HEART		C. BREASTS			
YES	NO		YES	NO	YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump	
<input type="checkbox"/>	<input type="checkbox"/>	Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family history of breast cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous mammogram date _____	
<input type="checkbox"/>	<input type="checkbox"/>	Spots in front of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
YES	NO	D. GASTROINTESTINAL	YES	NO	E. GENITO-URINARY	YES	NO	F. EXTREMITIES
<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty holding urine	<input type="checkbox"/>	<input type="checkbox"/>	Pain in legs when walking
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty starting urine	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots in legs
<input type="checkbox"/>	<input type="checkbox"/>	Bright blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urine	<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	<input type="checkbox"/>	Clay colored stools	<input type="checkbox"/>	<input type="checkbox"/>	Frequent night urination	<input type="checkbox"/>	<input type="checkbox"/>	New or growing moles
<input type="checkbox"/>	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	<input type="checkbox"/>	Change of color or urine	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood or pus in urine	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Wetting in bed	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting up blood						
<input type="checkbox"/>	<input type="checkbox"/>	Painful bowel movements						
<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting						

**THE WOMEN'S GROUP OF GWINNETT, P.C.
New Patient Gynecology Questionnaire**

NAME: _____

MEDICATIONS: (List ALL medications that you take regularly or have taken recently, include all non-prescription drugs.)

1. _____ 3. _____
2. _____ 4. _____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones) _____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT	_____	_____	_____
PREVIOUS	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family Members, the cause of death and their ages at death.) _____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

SOCIAL HISTORY:

Do you smoke cigarettes? () Yes () No How many/day? _____ How many years? _____
Do you drink alcohol? () Yes () No How many drinks/day? _____ Per week? _____
Do you get any regular exercise? () Yes () No How often? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period: _____ Age first started period: _____ Usual number of days from one period to the next: _____
Usual # of days of flow: _____ Are you periods: () Light () Moderate () Heavy any excessive bleeding or spotting between cycles? () Y () N
Cramps with periods? () Yes () No Depression, anxiety, emotional upset before periods? () Yes () No

PAP SMEARS:

Last pelvic exam: _____ Last Pap smear: _____ Have you ever had an abnormal pap? () Yes () No
If yes, what treatment was done? _____ Have your Paps been normal since treatment? () Yes () No
Did your mother take hormones while pregnant with you? () Yes () No

VAGINITIS:

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____
Are you having any problem with discharge now? () Yes () No

SEXUAL HISTORY:

Any problems with pain? () Yes () No Any problem with Orgasm? () Yes () No Other? _____
Any history of STDs? HPV () Yes () No Herpes () Yes () No Syphilis () Yes () No Hepatitis () Yes () No HIV () Yes () No
Gonorrhea () Yes () No Chlamydia () Yes () No Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

