Patient Name ___________________________

PRINT ENTIRE FORM
SINGLE SIDED

Overlake Reproductive Health

NEW GYNECOLOGICAL PATIENT QUESTIONNAIRE

IDENTIFYING INFORMATION: Date: _____/____/____ (of first visit)

Name: ____

Age: ________ yrs Birth date: _____/____/____

Address: ____

City/State/Zip: ____

Telephone (day): (______)____________________ (evening): (______)__________________

Occupation: ________________________________ Company: __________________________

Reason for visit: ____

____

What are your expectations for this visit? ________________________________

____

What questions do you want answered at this visit? ___________________________

____

How did you hear about us? (Please be as specific as possible)

☐ Physician

Name ____ Phone (______)_____________

Address ____

☐ Former Patient/Friend ____

☐ Web Site __________________________ ☐ Advertisement ________________________

☐ Insurance (Name of Insurance) ____

Who is your OB/GYN?

Name ____ Phone (______)_____________

Address ____

Who is your Primary Care Physician?

Name ____ Phone (______)_____________

Address ____

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I. GYNECOLOGICAL HISTORY:
FEMALE: (Menstrual and Pregnancy History)

Total # of all pregnancies: _______________

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

Date Pregnancy ended or delivered	Length of Pregnancy	How long to conceive	Result	Infertility Therapy?
1.	wks			
2.	wks			
3.	wks			
4.	wks			
5.	wks			

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

Explain: 1. ____

2. ____

3. ____

4. ____

Did you require? (circle pregnancies that apply):

C-section	1	2	3	4	5
Surgery	1	2	3	4	5
Blood transfusion	1	2	3	4	5
Antibiotics	1	2	3	4	5
D & C	1	2	3	4	5
Other	1	2	3	4	5

Explain: 1. ____

2. ____

3. ____

4. ____

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Patient Name ________________________

Age at first period __________yrs.

Age when you first noticed: Breast development ___yrs Pubic hair ___yrs Underarm hair ___yrs

Date of the first day of your last period _______/_______/_______

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next? __________________________

How many days does your menstrual flow last? _______________

Do you consider your menstrual flow abnormal? Yes No
(circle): light heavy short long painful other ______________

Do you have severe cramping or pelvic pain with your periods?
Yes: ___ Always ___ Sometimes ___ Recently ___ In the past No

Do you have pain with intercourse? Yes No

Do you spot or bleed between periods? Yes No

Do you have pelvic pain between periods? (If it is a significant problem, please complete pelvic pain questionnaire)
Yes No

Do you have premenstrual symptoms other than cramps? Yes No

Do you need medication to bring on a period? Yes No

Are your periods now, or have they ever been irregular or unpredictable? Yes No
If yes:
1. When ____
2. Average # of periods in a year ____________________________
3. Shortest time in between periods __________________________
4. Longest time spent without menstruating ____________________

(M.D. use only) ____
____
____
____
____

Do you have acne or oily skin? Yes No

Do you have a breast discharge? Yes No

Are you currently breast feeding? Yes No

Do you have extra body hair? Yes: Where? _____________________________ No

What has been your maximum weight? __________ When? ________________

What has been your minimum adult weight? __________ When? _____________

Have you ever had a sudden weight change? Yes: When? _________________ No

Do you feel that you are underweight? Yes No

Do you feel that you are overweight? Yes No

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How many meals do you usually eat per day? __________

Do you follow a particular food diet or have any special dietary habits? Yes No

Have you ever been diagnosed with an eating disorder, such as anorexia or bulimia? Yes No

Have you ever used self-induced vomiting to control overeating? Yes No

Do you regularly participate in any vigorous exercise? Yes No

What: ____

Number of hours __________/week Number of miles __________/week

---

FEMALE: (Contraceptive History)

Have you ever taken oral contraceptives (“Pill”)?

Name ___________________________ From ______________ To ______________

Name ___________________________ From ______________ To ______________

Name ___________________________ From ______________ To ______________

Did you or your doctor note any problems? Yes No

Explain ____

____

Was it stopped because of a problem? Yes No

Explain____

____

Were there any problems with your cycles after stopping the “pills”? Yes No

Explain____

____

Have you ever used injectable contraception (Depo-Provera®, Lunelle™, etc.)?

Yes: Dates of use___________________________ Complications? _______ No

Have you ever used an IUD? Yes No

Name ______________________________; From __________ To __________

Name ______________________________; From __________ To __________

Did you note any problems? Yes No

(Circle) Pain Bleeding Fever Infection

Was it removed because of a problem? Yes No

Explain____

____

Have you had tubal sterilization procedure (tubes tied)? Yes: _______ Date (mnth/yr) No

If yes, have you had a tubal reversal (tubes untied)? Yes: _______ Date (mnth/yr) No

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FEMALE: (Uterine, Tubal, Pelvic)

Have you ever had any of the following sexually transmitted diseases or pelvic infections?
Yes (check all that apply) No

☐ Chlamydia: date _____ ☐ Gonorrhea: date _____ ☐ Herpes: date _____ ☐ Genital warts/HPV: date _____
☐ Syphilis: date _____ ☐ HIV/AIDS: date _____ ☐ Hepatitis: date _____ ☐ Other________: date _____

Have you had your appendix removed? Yes No
(Circle one): Uncomplicated Ruptured Complicated Infection

Did your mother take any hormones when she was pregnant with you? Yes No

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? Yes No
Explain: ____
____

Have you ever had any of the following?

Procedure	Dates	Results
Endometrial Biopsy:		
Hysteroscopy:		
Laparoscopy:		
Tubal Surgery:		
Abdominal Surgery:		
Other Pelvic Surgery:		

Have you ever been noted to have or been treated for endometriosis? Yes No
Treatment: ____
____

II. FEMALE FAMILY HISTORY

Relative	Alive/Dead		Age
Mother ______________________	A/D	____________	__________
Father ______________________	A/D	____________	__________
Sisters/Brothers:			
1. S / B ______________________	A/D	____________	__________
2. S / B ______________________	A/D	____________	__________
3. S / B ______________________	A/D	____________	__________
4. S / B ______________________	A/D	____________	__________

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Have any of your blood relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Birth defects	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Other chromosome defects	M	F	S	O
Frequent miscarriages	M	F	S	O
Stillbirths	M	F	S	O
Twins	M	F	S	O
Early menopause (before age 40)	M	F	S	O
Endometriosis	M	F	S	O
Infertility	M	F	S	O
Irregular periods	M	F	S	O
Obesity	M	F	S	O
Psychiatric problems	M	F	S	O

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel or ovarian cancer)? Yes No

III. FEMALE MEDICAL HISTORY:

Do you have or have you ever had (circle all that apply):

Scarlet fever
Rheumatic fever
Tuberculosis
Hepatitis
Heart murmur
Pelvic infection
Chicken pox
Thyroid problems
Cancer
Kidney infection
Heart disease

High blood pressure
Gallbladder problems
Liver problems
Ulcers
Appendicitis
Colitis
Anemia
Arthritis
Breast lump
Breast problems
Breast discharge

Neurological problems
Seizures
Epilepsy
Dizziness
Loss of balance
Chronic headaches
Vaginitis
Pneumonia
Parasites
Ovarian cysts
Other ___________________

Comments ____

____

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PAP SMEAR HISTORY

When was your last pap smear? (month/year) _____/_____ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear? _____/_____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

Yes (check all that apply) No

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram?

Yes - date ______ Result: ☐ normal ☐ abnormal - explain ________________ No

Do you perform breast self exams? Yes No

Have you ever had Rubella (German measles)? Yes No

Have you received Rubella immunization? Yes No

Have you ever undergone surgery? Yes No

Date	Type	Hospital

Were there:

Complications? Yes No

Anesthesia problems? Yes No

Bleeding problems? Yes No

Comments ____

____

____

Are you allergic to any medication, drugs, foods, metals, other? Yes (list and describe reactions) No

____

____

____

Do you regularly take medications? Yes No

1. Over the counter (list) Yes No

____

2. Prescriptions (list) Yes No

____

____

3. Are you taking any now (list) Yes No

____

____

____

Do you use or have you ever used:

1. Alcohol, (# of glasses per week) Wine ____ Beer ____ Cocktails ____ Yes No
2. Cigarettes, (present ________ prior ________) Yes No
   # packs per day ________ # of years ________
3. Illicit or recreational drugs (specify) Yes No

____

____ **Past / Present (circle)**

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COUPLE FACTORS (OPTIONAL)

How frequently do you have sexual intercourse?

- More than once a day ________
- Daily or almost daily ________
- 3-5 times a week ________
- 1-2 time a week ________
- Less than once a week ________
- Irregularly ________

Which of the following best describes how you feel about your sex life?

- Very satisfied ________
- Fairly satisfied ________
- Fairly unsatisfied ________
- Very unsatisfied ________

Which of the following best describes how you think your partner feels about your mutual sex life?

- Very satisfied ________
- Fairly satisfied ________
- Fairly unsatisfied ________
- Very unsatisfied ________

Do any of these statements describe sex with your partner?

- It is sometimes difficult ________
- It is almost always difficult ________
- It is sometimes painful ________
- It is almost always painful ________
- It is sometimes unpleasant ________
- It is almost always unpleasant ________
- It is sometimes enjoyable ________
- It is almost always enjoyable ________

Do you or your partner have problems with initiating or completing sexual intercourse? Yes No

Do you plan intercourse for a specific time of your cycle? Yes No
When: ____

Do you use lubricant for intercourse? Yes No

Do you douche before or after intercourse? Yes No

Do you feel that your fertility problem is:

1. Causing personal stress Yes No
2. Causing stress between you and your husband Yes No
3. Interfering with a satisfactory sex life Yes No

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IV. REVIEW OF SYSTEMS

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other ___________________________
- ☐ none

Endocrine/Hormonal:
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance - hot flashes or feeling cold
- ☐ Other ___________________________
- ☐ none

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other ___________________________
- ☐ none

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other ___________________________
- ☐ none

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other ___________________________
- ☐ none

Head, Eyes, Ears, Nose and Throat:
- ☐ Dizziness ☐ Loss of sense of smell
- ☐ Headaches ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other ___________________________
- ☐ none

Breasts:
- ☐ Discharge: clear __ bloody __ milky __
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants Saline __ Silicone __
- ☐ Other ___________________________
- ☐ none

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other ___________________________
- ☐ none

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle Cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons ______________)
- ☐ Other ___________________________
- ☐ none

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other ___________________
- ☐ none

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other ___________________
- ☐ none

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other ___________________
- ☐ none

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (need antibiotics before dental procedures? Yes ___ No ___)
- ☐ Other ___________________
- ☐ none

Physician Notes (for office use only) ____

____

____

____

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V. PHYSICAL EXAM:

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Height ____________ Weight ___________ Pulse ____________ B.P. ___________

Stature ___________________________________ Race ___________________________

General Appearance: ☐ Well developed ☐ Well nourished ☐ Normal mood/affect ☐ Oriented x3 ☐ No acute distress

Skin: ☐ Acne ☐ XS Sebum ☐ Hirsuitism (facial, chest, back, areolar, abd., thigh) ☐ No lesions ☐ No abnormal moles

Neck: ☐ Supple ☐ Without masses

Thyroid: ☐ WNL ☐ No masses ☐ Without thyromegaly

Breast: ☐ No dominant masses ☐ No skin changes ☐ No nipple discharge

Lungs: ☐ Clear to auscultation bilaterally ☐ Normal respiratory effort

Heart: ☐ Regular rhythm and rate ☐ No murmurs/gallops

Abdomen: ☐ Soft, non-distended ☐ No masses/HSM ☐ No hernias

Back: ☐ No CVA tenderness

Lymphatic: ☐ No neck ☐ No axillary ☐ No groin lymphadenopathy

Extremities: ☐ Without varicosities ☐ Without edema ☐ Nontender calves

Pelvic Exam: ☐ Normal external genitalia ☐ Adnexa NT

Urethral meatus/urethra: ☐ Without lesions, tenderness or prolapse

Bladder: ☐ Without masses, tenderness ☐ Well supported

Vagina: ☐ Well supported ☐ No lesions ☐ No abnormal discharge

Cervix: ☐ Without lesions ☐ No CMT

Uterus Position: ☐ Normal size & shape ☐ Nontender ☐ Without descent

Adnexa: ☐ Normal size ☐ No adnexal masses ☐ No tenderness

Anus/Perineum: ☐ No lesions

Rectal: ☐ Normal sphincter tone ☐ No hemorrhoids ☐ No tenderness

Other Findings:

The above was discussed with the patient at the New Patient Consultation.

Signed: ____ Date: ____________________

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F. IMPRESSION