Gondra Center
for Reproductive Care & Advanced Gynecology

| New Patient Questionnaire | | | |
|---|---|---|---|
| Name | | Date: | |
| Date of Birth: | Age: | | |

***Ethnic Backgrounds****- Please check if you have any of the following ethnic backgrounds*

Jewish- Ashkenazi ☐ Jewish-Sephardic ☐ French Canadian ☐ Mediterranean ☐ Cajun☐ Middle Eastern ☐ Unsure ☐

| | | |
|---|---|---|
| Partner (if applicable) Name: | Date of Birth: Age: | |
| Occupation: | | |
| Home Phone #: | Cell phone #: | |
| Pharmacy Name: | Pharmacy Address: | |
| Email: | SSN: | |

***MEDICATIONS****: Please list any medications you take, including over-the-counter.*

| Medicine | Dose | How often? | Medicine | Dose | How often? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Current medical concerns. Pease check if you had any of the following symptoms this week.**

| | | |
|---|---|---|
| Weight change Y ☐ N ☐ | Nausea/Vomiting Y ☐ N ☐ | Trouble sleeping Y ☐ N ☐ |
| Abnormal bleeding Y ☐ N ☐ | Bowel changes Y ☐ N ☐ | Night sweats Y ☐ N ☐ |
| Abnormal hair growth Y ☐ N ☐ | Anxiety/Panic Y ☐ N ☐ | Hot flashes Y ☐ N ☐ |
| Problems with urination Y ☐ N ☐ | Depression Y ☐ N ☐ | Breast problems Y ☐ N ☐ |

***MEDICAL /FAMILY HISTORY*** *- Please check if you or a blood-relative have had any of the following:*

| | *Myself* | *Family* | | *Myself* | *Family* | | *Myself* | *Family* |
|---|---|---|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | Mental illness | ☐ | ☐ | Liver disease | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Depression | ☐ | ☐ | Gall bladder | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | Anxiety | ☐ | ☐ | Blood clots | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Eating disorder | ☐ | ☐ | Blood transfusion | ☐ | ☐ |
| Stroke | ☐ | ☐ | Migraine headaches | ☐ | ☐ | Breast cancer | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Urinary tract infection | ☐ | ☐ | Colon cancer | ☐ | ☐ |
| COPD/Emphysema | ☐ | ☐ | Lupus | ☐ | ☐ | Ovarian cancer | ☐ | ☐ |
| Asthma | ☐ | ☐ | Arthritis | ☐ | ☐ | Other cancer, Specify: | | |
| Seizures | ☐ | ☐ | Back injury | ☐ | ☐ | | | |
| Thyroid problems | ☐ | ☐ | Osteoporosis | ☐ | ☐ | History of TB disease | ☐ | ☐ |

***ALLERGIES***

Do you have any allergies? Y ☐ N ☐ **If yes, what and your reaction?**

***SURGICAL HISTORY***

Please list and surgeries, including your age when you had it

***HOSPITALIZATION HISTORY***

Please list any hospitalizations, including your age when you had it.

| ***CONTRACEPTIVE and SEXUAL HISTORY*** | | | |
|---|---|---|---|
| If using birth control, what method do you currently use? | | | |
| Birth control methods you have used in the past? | Length of use ? | Reason for discontinuation? | |
| 1. | | | |
| 2. | | | |
| Have you been sexually active (had intercourse)? Y ☐ N ☐ | | | |
| Have you had a new sexual partner in the past 3 months? Y ☐ N ☐ | | | |
| How many sexual partners have you had in the past 3 months? | | | |
| IS/Are your partners male ☐ female ☐ both ☐ | | | |
| Do you experience pain or discomfort with sexual intercourse? Y ☐ N ☐ | | | |
| Would you like to discuss sexual activity or birth control today? Y ☐ N ☐ | | | |

| ***PERSONAL/SOCIAL HISTORY*** | Y or N | |
|---|---|---|
| Do/Did you use tobacco products? | ☐ ☐ | How much? |
| Do/Did you drink alcohol? | ☐ ☐ | How many per week? |
| Do/did you drink caffeine? | ☐ ☐ | How much daily? |
| Do/did you use illicit drugs? | ☐ ☐ | Which drugs? |
| Have you ever been tested for HIV? | ☐ ☐ | Year and result? |
| Have you been a victim of physical, verbal, sexual or emotional abuse? Y ☐ **N** ☐ | | |

| ***GYNECOLOGICAL HISTORY*** | | | | |
|---|---|---|---|---|
| Have you been vaccinated for Human Papilloma Virus? Y ☐ N ☐ | | | | |
| Last Pap Smear: | Last Mammogram: | | Last Bone Density (DEXA): | |
| Last Colonoscopy: | | | | |
| Have you ever been on hormone therapy (estrogen /progesterone) Y ☐ N ☐ | | | | |
| **Any personal history of :** | Abnormal Pap Smear Y ☐ N ☐ | | Sexually Transmitted Diseases Y ☐ N ☐ | |
| Uterine Fibroids Y ☐ N ☐ | Endometriosis Y ☐ N ☐ | | Infertility Y ☐ N ☐ | |
| Urinary Incontinences Y ☐ N ☐ | | | | |

| ***MENSTRAUL HISTORY*** | |
|---|---|
| First day of last period? | Age at first menstrual period? |
| The # of days from the start of one period to the next. | Number of days that you bleed? |
| Describe the amount of menstrual flow (check one) light ☐ moderate ☐ heavy ☐ clots ☐ | |
| How many tampons or pads do you use on your heaviest day? | Do you bleed after intercourse? Y ☐ N ☐ |
| Do you bleed between your periods? Y ☐ N ☐ | If you stopped menstruating, at what age did you stop? |
| Have you been bleeding or spotting since your period stopped? Y ☐ N ☐ | |

| ***OBSTETRICAL HISTORY*** | | | | |
|---|---|---|---|---|
| Number of: Pregnancies: | Vaginal Birth: | Living Children: | C-Section(s): | |
| Miscarriages: | Ectopic: | Abortions: | | |