ANDERSON GYNECOLOGY & AESTHETICS
94 OLD MILL ROAD
MARTINSBURG, WV 25401
TEL: (681)260-2016 FAX: (681)260-2020

NEW PATIENT QUESTIONNAIRE

Name:_____ **Date of Birth**: _____

Social Security #: _____Age: _____

Address:_____

City: _____ State: _____Zip Code: _____

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Email Address: _____

May we leave a message? • Home • Work • Cell • PLEASE DO NOT LEAVE A MESSAGE

Marital Status: Single Married Widowed Divorced Separated

Occupation: _____FULL-TIME PART-TIME

UNEMPLOYED RETIRED FULL-TIME STUDENT PART-TIME STUDENT

EMPLOYER:_____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DEPARTMENT: _____TELEPHONE NUMBER: ( ) _____

Were you referred from another physician? __yes __no Name of referring physician_____

Primary Physician: _____

How did you hear about our practice? (please circle) FRIEND/FAMILY MEMBER : _____

HOSPITAL NEWSPAPER TELEPHONE BOOK INTERNET(website) FACEBOOK

OTHER: _____

PREFERRED PHARMACY:_____

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE #: _____ RELATIONSHIP TO PATIENT: _____

I AUTHORIZE THE OFFICE OF ANDERSON GYNECOLOGY & AESTHETICS TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT TO THE FOLLOWING DESIGNATED PERSON. (THIS PERSON MAY BE SOMEONE OTHER THAN YOUR EMERGENCY CONTACT. IF NOONE, PLEASE INDICATE.)

NAME: _____ *TELEPHONE NUMBER ( ) _____*

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REASON FOR YOUR VISIT TODAY: _____

GENERAL HEALTH

Do you exercise regularly? __yes __no

Self Breast examination monthly? __yes __no

Do you follow a special diet? __yes __no If yes, please specify? _____

Which response describes your general health? **EXCELLENT GOOD FAIR POOR**
Are you able to perform normal activities at home? __Yes __No If no, explain: _____

_____

CIRCLE ANY SIGNIFICANT SYMPTOMS BELOW THAT YOU CURRENTLY HAVE

CONSTITUTIONAL
fever
chills
night sweats
hot flashes
weight changes
appetite changes

BREAST
breast pain
breast lump
breast discharge
breast swelling
skin changes

MUSCULOSKELETAL
joint pain
joint swelling
back pain
weakness
difficulty walking
numbness/tingling

ENDOCRINE
excessive thirst
excessive urination
heat/cold intolerance

GENITOURINARY
heavy bleeding
bleeding between periods
painful periods
irregular periods
bleeding after intercourse
vaginal discharge/odor
vaginal dryness
vaginal itching
vaginal sores
abnormal growths
pelvic pain
pelvic fullness/pressure
change in sexual desire
change in sex partner
sexual difficulty
pelvic prolapse
pain with intercourse
pain with urination

CARDIOVASCULAR
chest pain
palpitations

RESPIRATORY
shortness of breath
cough
sputum production

GASTROINTESTINAL
nausea
vomiting
constipation
diarrhea
abdominal pain
bloating/cramping
change in appetite
bloody stool
black, tarry stool

NEUROLOGIC
headaches
seizures
weakness

PSYCHOLOGICAL
depression
anxiety
mood swings
nervousness

MENSTRUAL HISTORY

First day of your last menstrual period? ___/___/_____ Number of days bleeding _____ Flow: Light Medium Heavy

Number of days between periods? _____ Pain with periods? Yes No Bleeding between periods? Yes No

At what age did your periods start? _____ At what age did your periods stop: _____

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OB/GYN HISTORY

Current contraceptive method(s): _____

Are you sexually active? Yes No Partner: Male Female

Have you ever had a sexually transmitted infection? Yes No If yes, please list:_____

Have you ever had Pelvic Inflammatory Disease? Yes No If yes, when: _____

Are you currently using Hormone Replacement Therapy? Yes No If yes, what type?: _____

Do you have pain with intercourse? Yes No N/A Vaginal dryness or discomfort? Yes No

Number of pregnancies_____ Live births _____ Miscarriages _____ Ectopic _____ Elective terminations _____

Number of Living Children _____

Age and sex of Living Children: _____

Date of last delivery: _____ Number of vaginal deliveries: _____ Number of cesarean deliveries _____

Any pregnancy complications? _____

Date of last Pap smear: _____ Where was last Pap smear done? _____

Have you ever had an abnormal Pap smear: __ Yes __ No If yes, when? _____

Was it treated with any of the following? __Frequent follow-up Pap smears __Colposcopy __ Biopsy

__Cryotherapy __Cone biopsy __ LEEP __Hysterectomy

Date of last Mammogram: _____ Where was your last Mammogram done?_____

Date of last Bone Density scan: _____ Where was Bone Density scan done? _____

Date of last Colonoscopy: _____ Where was colonoscopy done? _____

Have you ever had chronic pelvic pain? __Yes __No

Do you have pain now? __Yes __No If yes, location:_____

On a scale of 1-10, how do you rate your pain? **No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain**

SOCIAL HISTORY

Tobacco use __yes __no How much? _____packs/day Former Smoker ___yes ___no
Alcohol use __yes __no How much? _____drinks /week
Drug use __yes __no If yes, list the type_____

Caffeine use __yes __no How much? _____cups/day

MEDICATIONS

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NEW PATIENT QUESTIONNAIRE

MEDICATION	DOSE	WHAT ARE YOU TAKING IT FOR

ALLERGIES

MEDICATION	REACTION

FAMILY HISTORY

Is your Mother alive? __yes __no If no, age and cause of death: _____

Is your Father alive? __yes __no If no, age and cause of death: _____

How many brothers do you have? _____How many sisters do you have? _____

LIST ALL RELATIVES WHO HAVE HAD A MAJOR ILLNESS (DIABETES, HEART DISEASE, CANCER, HIGH BLOOD PRESSURE…)		
RELATION	**TYPE OF ILLNESS**	**AGE AT DIAGNOSIS**

MEDICAL HISTORY

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NEW PATIENT QUESTIONNAIRE

DATE	MEDICAL PROBLEM	PHYSICIAN

SURGICAL HISTORY

DATE	SURGERY/PROCEDURE	PHYSICIAN/HOSPITAL

If HYSTERECTOMY, what was removed? UTERUS ONE OVARY BOTH OVARIES

Any prior procedures on your cervix? _____

Any prior procedures on your breasts? _____

Patient Name: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____