ANDERSON OBSTETRICS & GYNECOLOGY, PLLC
1008 TAVERN ROAD SUITE 203
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: ______________________

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I AUTHORIZE THE OFFICE OF ANDERSON OBSTETRICS AND GYNECOLOGY, PLLC 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 (   )* ____________________

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: ____________________________

____

Are you currently or have you ever experienced mental, physical, emotional, or sexual abuse? __Yes __No

If yes, please explain: ____

Do you currently feel safe in your home? __Yes __No

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

CARDIOVASCULAR
Chest pain
Palpitations

RESPIRATORY
shortness of breath
cough
sputum production

GASTROINTESTINAL
nausea
vomiting
constipation
diarrhea

NEUROLOGIC
headaches
seizures
weakness

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PSYCHOLOGICAL
Depression
Anxiety
Mood swings
Nervousness

Abdominal pain
Bloating/cramping
Change in appetite
Bloody stool
Black, tarry stool

change in sex partner
sexual difficulty
pelvic prolapse
pain with intercourse
pain with urination

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

Bleeding after intercourse? Yes No

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

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 ______ Ectopics ______ 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? ________________________

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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

MEDICATION	DOSE	WHAT ARE YOU TAKING IT FOR

ALLERGIES

MEDICATION	REACTION

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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

DATE	MEDICAL PROBLEM	PHYSICIAN

SURGICAL HISTORY

DATE	SURGERY/PROCEDURE	PHYSICIAN/HOSPITAL

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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: ______________