NEW PATIENT PROBLEM VISIT QUESTIONNAIRE

Name: Date of Birth:

Current Medications (include hormones, herbs, vitamins, nonprescription medicine)	
Name and Dosage	**Name and Dosage**
1.	4.
2.	5.
3.	6.

Allergies (Please include all drug allergies)	
1.	3.
2.	4.

Today's Visit

What brings you into the office today?

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis/Joint pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clots in lungs or legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidney Infections/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Problem	Yes	No	Problem	Yes	No
Abnormal hair growth			Infertility		
Abnormal Bleeding			Ovarian Cyst		
Abnormal Pap Smear			Osteoporosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexually transmitted disease		
DES Exposure			Uterine Abnormality		
Endometriosis			Urinary Leakage		
Fibroid Uterus			Vaginal/Vulvar Infection		

Surgeries

Surgery	Yes	No	Date/Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysteroscopy (outpatient)			
Laparoscopy (outpatient)			
Vaginal Surgery			
Bartholin Glands Surgery			
Other (Please List):			

PLEASE TURN THE PAGE OVER AND CONTINUE.

Social History		
Preferred Name:	PCP:	Occupation:
Number of people in household:	Single Married Widowed Divorced Separated Living w/ partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: Always Frequently Occasionally Never		
Occupational Risks: None Biohazard Chemical Physical Labor		
How many days per week do you exercise?	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? cocaine narcotics marijuana hallucinogens		

Family History- Please check those that apply							
Illness	**Mother**	**Father**	**Sibling**	**Child**	**Maternal Grandparent**	**Paternal Grandparent**	**Other**
Breast Cancer							
Colon Cancer							
Ovarian Cancer							
Alzheimer's Disease							
Birth Defects							
Blood Clots in lungs or legs							
Diabetes							
Drinking or Drug problems							
Endometriosis							
Fibroids							
Heart Disease							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV/AIDS							
Mental Illness/Depression							
Osteoporosis							
Stroke							
Tuberculosis							
Other							

Obstetric History											
#Total Pregnancies		#Full Term		#Premature		#Elective Abortion					
# Miscarriage		#Ectopic		#Multiples		#Living					
Pregnancy #	**1**		**2**		**3**		**4**		**5**		**6**
Pregnancy Outcome:F=Full term, P=Premature, M=Miscarriage											
Delivery Date											
Weeks at Delivery											
Length of labor (hrs.)											
Epidural/Anesthesia											
Delivery Type V=Vaginal, C=C-Section											
Did you have Pre-term Labor?											
Delivery Location											
Who delivered your baby?											
Baby weight?											
Baby Sex?											
Baby Name?											
Complications	**Please check any that apply**										
Gestational Diabetes											
Macrosomia											
Multiple Gestation											
Post Dates											
Post partum hemorrhage											
Pre-eclampsia											
Preterm Delivery											
Other Complications											

STI TESTING CONSENT

We offer **STI (Sexually Transmitted Infection) Testing.** Many insurance carriers cover testing during your Annual Visit **AND/OR** if exposure has occurred. However, it is impossible for our office to know each individual carrier's plan and the benefits provided therein. If there are any questions regarding your coverage for STI Testing, please contact your insurance carrier. If your carrier does not cover the costs of this testing, additional charges from the laboratory may apply. If this is the case, you will receive a separate bill from the laboratory for any uncovered services.

Below, please check mark:
1) If you **DO or DO NOT** desire to have STI testing completed at today's visit.
2) If you **DO** desire testing, please place a check mark next to each test that you would like to have completed.
3) Please write your name, sign, and date the bottom of this page.

_____ I **DO NOT** desire STI testing at this time.

_____ I **DO** desire STI testing--Initial by the test you want performed today.

_____ **CHLAMYDIA**

_____ **GONORRHEA**

_____ **BV/YEAST**

_____ **TRICHOMONIASIS ("TRICH")**

_____ **HSV 1 (HERPES SIMPLEX VIRUS 1) */****

_____ **HSV 2 (HERPES SIMPLEX VIRUS 2) */****

_____ **HBV (HEPATITIS B VIRUS) ***

_____ **HCV (HEPATITIS C VIRUS) ***

_____ **HIV (HUMAN IMMUNODEFICIANCY VIRUS) ***

_____ **RPR (SYPHILIS)**

_____
PATIENT NAME

_____ _____
PATIENT (GUARDIAN) SIGNATURE DATE

_____ _____
WITNESS DATE

**** IF TEST RESULTS HAVE BEEN POSITIVE PREVIOUSLY, REPEAT TESTING IS NOT RECOMMENDED.***

*****THIS IS AN ANTIBODY TEST AND ONLY TESTS FOR EXPOSURE TO HERPES. A POSITIVE RESULT DOES NOT MEAN THAT A PERSON IS A CARRIER FOR THE HERPES VIRUS.***