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PATIENT QUESTIONNAIRE

Please bring this completed form to your scheduled appointment (DO NOT MAIL).

Name: _____ Age: _____ Date/Time: _____

What brings you to the office today: _____

Who referred you to our office: _____

Do you have any questions, problems, or concerns that you would like to discuss with us today? _____

MENSTRUAL/GYNECOLOGICAL HISTORY

Date of your last period: _____

Has there been a change in your periods? Yes No If yes, please specify: _____

Do you have hot flashes, night sweats, or trouble sleeping? Yes No If yes, please specify: _____

Are you taking any hormones? Yes No If yes, please specify: _____

Are you taking any vitamin, calcium, herbal or other supplements? Yes No If yes, please specify: _____

Age period started: _____ # of days your period last: _____ Days between periods: _____

Cramps? Yes No PMS? Yes No

OBSTETRICAL HISTORY

Number of pregnancies _____ Vaginal deliveries _____ C-Section _____ Miscarriages _____ Abortions _____

SEXUALITY HISTORY

Do you use a method of contraception? Yes No

If yes, what type? pills IUD diaphragm spermicide natural/rhythm

sponge condoms other _____

Do you want any information about birth control/safer sex? Yes No

Have you ever had: Chlamydia Gonorrhea Syphilis Venereal Warts Herpes

Do you have pain with sexual intercourse? Yes No

Any other problems with sex? _____

URINARY HISTORY

Do you lose urine involuntarily? Yes No
Do you frequently have a strong, sudden urge to urinate? Yes No
Do you get up 2 or more times during the night to go the bathroom? Yes No
Do you sometimes not make it to the bathroom in time? Yes No
Do you to the bathroom more than 8 times during a 24-hour period? Yes No

BREAST HISTORY

Do you have fibrocystic condition Yes No
Have you ever had a breast lump or cyst Yes No Biopsy results: _____
Do you experience breast pain? Yes No
When was your last mammogram? _____ Results: _____
Where was your last mammogram performed? _____

SCREENING SECTION:

Date of your last Pap test: _____ Date of your last stool test: _____
Have you ever had an abnormal Pap? Yes No If yes, please specify: _____
Have you had a colon examination ("**sigmoidoscopy**") within three to five years after age 50 (more often for high-risk people)?
Yes No If yes, when? _____
Have you ever had a Bone Density Exam? Yes No If yes, when? _____

MEDICAL HISTORY

Have you had any illnesses? Yes No If yes, please specify: _____
Please list all doctors who you see now: **Primary Care:** _____ **Specialist:** _____
Please list all medications including herbal and OTC _____
Drug allergies? Yes No If yes, please specify: _____
Food or environmental allergies? Yes No Results: _____
Has your cholesterol been tested? Yes No Don't Know
Are your blood tests normal? Yes No Have not had
Do you get regular dental and eye exams? Yes No Any Problems? _____
Do you have problems hearing? Yes No
Vaccine History Date: _____ Tetanus _____ Hep. B _____ Hep. A _____ Flu _____ HPV (Gardasil)

SURGICAL HISTORY

Please list all surgeries - gynecological, plastic, or other. Please include dates/year. _____

FAMILY MEDICAL HISTORY

Have you or anyone in your family (parents, brothers, sisters, children, grandparents, aunts, uncles, cousins) ever been diagnosed with:

	SELF		FAMILY	
	YES	<i>If yes, when diagnosed</i>	YES	<i>If yes, Who?</i>
Heart Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Lung Problems	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Blood Disorders	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Early Menopause	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
DES Exposure	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Tubal Infection	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Infertility	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Varicose Veins	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Uterine Cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Lung Cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Melanoma/Skin Cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
More than 1 kind of cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Diagnosed in the same person		_____	<input type="checkbox"/>	_____
Other types of cancer	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Birth Defects	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Mental Retardation	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Multiple miscarriages	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Childhood Tumors	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

SOCIAL HISTORY

What is your occupation? _____ Have you recently changed jobs? Yes No

Do you have any problems at home? Yes No *If yes, please specify:* _____

Has there been any change in your relationship with your husband, partner, or boyfriend? Yes No

If yes, please specify: _____

How are you relationships with others? _____

Do you suffer from anxiety or depression? _____

Do you smoke cigarettes? Yes No FORMER *How much/how long?* _____

Do you use street drugs? Yes No *If yes, please specify:* _____

Do you drink alcohol on a regular basis? Yes No *If yes, please specify:* _____