WINCHESTER OB-GYN ASSOCIATES, P.C.

New Patient History Questionnaire

Date:_____

Patient Name:_____ DOB:_____

Marital Status: ☐Single ☐ Married ☐ Long Term Relationship ☐ Divorced ☐ Widowed

PCP:_____ Referring Physician (if different than PCP):_____

Preferred phone number:_____ Occupation/Employer:_____

Reason for this visit:_____

Have you recently experienced any of the following?: (*check any that apply*)

☐ Weight changes	☐ Urinary frequency/pain	☐ Fatigue	☐ Chest Pain / Palpitations
☐ Appetite changes	☐ Blood in urine or stool	☐ Bowel/urinary incontinence	☐ Breast discharge
☐ Hair loss	☐ Weakness/numbness	☐ Skin changes/rash	☐ Breast pain/mass
☐ Headache	☐ Pelvic pain	☐ Depression/anxiety	☐ Hot flashes/Night sweats
☐ Difficulty breathing	☐ Pain/bleeding with intercourse	☐ Other:_____	

CURRENT MEDICATIONS

Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:

PAST MEDICAL HISTORY (*check any that apply* or ☐ NONE)

☐ Diabetes	☐ Kidney Infection/Stones	☐ Asthma	☐ Arthritis/Joint Pain	☐ High Blood Pressure
☐ Liver Disease/Hepatitis	☐ Heart Problem/Murmur	☐ HIV+	☐ Heart Disease	☐ Tuberculosis
☐ Anxiety/Depression	☐ MRSA/drug-resistant infection	☐ Cancer	☐ Lung Disease	☐ Thyroid Disease
☐ Seizures/Epilepsy	☐ Bowel Problems / Ulcer	☐ Stroke	☐ Eye Problems	☐ Other:_____
☐ Migraines	☐ Anemia/Blood Transfusion			

DRUG ALLERGIES ☐ NO ☐ YES *If yes, please list drug name and reaction*:

_____

_____

GYNECOLOGIC HISTORY

Date of last pap smear: _____

Have you ever had an abnormal pap smear? ☐ YES ☐ NO If yes, month/year of abnormal pap:_____

Have you had treatment for an abnormal pap smear? ☐ YES ☐ NO

If yes, what type of treatment(s) have you had? (*please include year*)

☐ Colposcopy_____ ☐ Cryotherapy_____ ☐ Laser_____ ☐ Cone Biopsy_____ ☐ LEEP_____

MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

Age at first period: _____years First day of last period: ____/____/____

Your menstrual periods start every: _____days Duration of bleeding: _____days

Does bleeding or spotting occur: ☐ between periods? ☐ after intercourse?

Is pain associated with periods? ☐ YES ☐ NO ☐ OCCASIONALLY

If yes, is it: ☐ before menses? ☐ during menses? ☐ both?

For postmenopausal women: Menopause at age:_____ Any postmenopausal bleeding? ☐ YES ☐ NO

SEXUAL HISTORY

Do you have a sexual partner? ☐ NO ☐ YES (☐ MALE ☐ FEMALE ☐ BOTH)

What birth control method(s) do you currently use?_____

HISTORY OF SEXUALLY TRANSMITTED DISEASE

Check any that apply: ☐ Syphilis ☐ HPV/Genital Warts ☐ Trichomonas ☐ Chlamydia ☐ HIV
☐ Gonorrhea ☐ Herpes ☐ Pelvic Inflammatory Disease ☐ None

IMMUNIZATIONS (*please list month/year*)

Gardasil Series (HPV vaccine):_____

OTHER EXAMS: (*please include month and year of your last exam*)

Mammogram:_____ Colonoscopy:_____ Bone Density Screening: _____

OBSTETRICAL HISTORY ☐ HAVE NEVER BEEN PREGNANT

	NUMBER		NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES		LIVE CHILDREN	

BIRTHDATE OF CHILD	SEX OF CHILD	BIRTH WEIGHT OF CHILD	HOSPITAL OR LOCATION CHILD WAS BORN	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL or CESAREAN)

PAST SURGICAL HISTORY (*List all surgeries and their year* or ☐ NONE)

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

FAMILY HISTORY

Is there any family history of breast, colon, uterine, prostate or ovarian cancer? ☐ YES ☐ NO

Is there any family history of bleeding or clotting disorders or stroke? ☐ YES ☐ NO

FAMILY MEMBER	YEAR BORN	ALIVE/DECEASED?	MEDICAL HISTORY / AGE AT TIME OF DEATH
Father			
Mother			
Brother			
Sister			
Daughter			
Son			
Spouse			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			

_____ _____

Signature of Patient ***Date***

_____ _____

Signature of Provider ***Date***