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***