THE WOMEN'S GROUP OF GWINNETT, P.C.
New Patient Gynecology Questionnaire

NAME:______________________________ **DATE**:______________

DATE OF BIRTH:______________________

REASON FOR VISIT: (If not routine, briefly describe main symptoms.)______________________________

____

PAST MEDICAL HISTORY:

List all operations you have had.

	OPERATION	DATE
A.		
B.		
C.		
D.		
E.		

List all illnesses you have had that required hospitalization.

	ILLNESS	DATE
A.		
B.		
C.		
D.		
E.		

Have you ever had? (Check yes or no and give dates.)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	
( )	( )	Thyroid Disorder	
( )	( )	Pneumonia	
( )	( )	Tuberculosis	
( )	( )	Heart Murmur	
( )	( )	High Blood Pressure	
( )	( )	Rheumatic Fever	
( )	( )	Diabetes	
( )	( )	German Measles or Vaccine	
( )	( )	Anemia	
( )	( )	Convulsions or Seizures	
( )	( )	Ulcers	
( )	( )	I will accept blood products if necessary	

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	
( )	( )	Kidney Stones	
( )	( )	Kidney Infection	
( )	( )	Bladder Infection	
( )	( )	Genital Herpes	
( )	( )	Gonorrhea	
( )	( )	Syphilis	
( )	( )	Broken Bones	
( )	( )	Arthritis	
( )	( )	Mental Illness	
( )	( )	Serious Injury	
( )	( )	Blood Transfusion	

Please list any additional medical conditions or illnesses.

ILLNESS	DATE

REVIEW OF SYSTEMS:

Are you currently having or have you recently had any of these symptoms? (Check "Yes" or "No")

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest discomfort on exertion
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C, BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast cancer
( )	( )	Previous mammogram date __________
( )	( )	

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color or urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Pain in legs when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

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NAME:____

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1.____________________________________ 3.____________________________________

2.____________________________________ 4.____________________________________

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones) ______________________
____
____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT	________	________	________
PREVIOUS	________	________	________
	________	________	________
	________	________	________

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.	________	________	________	________	________
2.	________	________	________	________	________
3.	________	________	________	________	________
4.	________	________	________	________	________
5.	________	________	________	________	________
6.	________	________	________	________	________

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family Members, the cause of death and their ages at death.) ______________________________
____
____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?
____
____
____

SOCIAL HISTORY:
Do you smoke cigarettes? ( ) Yes ( ) No How many/day?________________ How many years?______________
Do you drink alcohol? ( ) Yes ( ) No How many drinks/day?___________ Per week?____________________
Do you get any regular exercise? ( ) Yes ( ) No How often?____________________

GYNECOLOGIC HISTORY:
MENSTRUAL HISTORY
First day of last period: _____________ Age first started period: _______________ Usual number of days from one period to the next:_______________
Usual # of days of flow: ____________ Are you periods: ( ) Light ( ) Moderate ( ) Heavy any excessive bleeding or spotting between cycles? ( ) Y ( ) N
Cramps with periods? ( ) Yes ( ) No Depression, anxiety, emotional upset before periods? ( ) Yes ( ) No

PAP SMEARS:
Last pelvic exam: ____________________ Last Pap smear: _____________________ Have you ever had an abnormal pap? ( ) Yes ( ) No
If yes, what treatment was done?_____________________________Have your Paps been normal since treatment? ( ) Yes ( ) No
Did your mother take hormones while pregnant with you? ( ) Yes ( ) No

VAGINITIS:
Yeast:__________________________ Trichomonas:______________________________ Non-specific/Bacterial Vaginitis:______________________
Are you having any problem with discharge now? ( ) Yes ( ) No

SEXUAL HISTORY:
Any problems with pain? ( ) Yes ( ) No Any problem with Orgasm? ( ) Yes ( ) No Other?_________________________________
Any history of STDs? HPV ( ) Yes ( ) No Herpes ( ) Yes ( ) No Syphilis ( ) Yes ( ) No Hepatitis ( ) Yes ( ) No HIV ( ) Yes ( ) No
Gonorrhea ( ) Yes ( ) No Chlamydia ( ) Yes ( ) No Other?____

List any Gynecologic surgeries, dates and reasons for surgery:____
____
____
____
____
____
____