

Associated Women's Healthcare, LLP

NEW PATIENT QUESTIONNAIRE

Name _____ Date _____

Age ____ Race _____ Married () Single () Divorced () Widowed ()

Drug Allergies _____

Last Menstrual Period _____ Cycles: Regular () Irregular ()

Have you had any abnormal pap smears in the past? Yes () No ()

Surgeries: Year _____ Description _____
 Year _____ Description _____

Hospitalizations (other than surgeries):
 Year _____ Description _____
 Year _____ Description _____

Medications _____ Dose _____ How Long? _____
 _____ Dose _____ How Long? _____

Contraception: _____ How Long? _____

Cigarettes _____ per day Alcohol _____ Drug Use _____

PREGNANCIES:		Dur. of	Type of	Type				Newborn
Year	Hospital	Pregnancy	Delivery	Anesthesia	Sex	Wt.		Complications

FAMILY HISTORY:	Age	Living	Deceased	Health or Cause of Death
Father				
Mother				
Siblings				

CIRCLE IF ANY BLOOD RELATIVE HAS HAD:

Heart disease Kidney disease Tuberculosis Mental disorder
 High blood pressure Diabetes Tumors Seizures

CIRCLE IF ANY BLOOD RELATIVE HAS HAD:

Down Syndrome Tay Sachs Muscular Dystrophy Hydrocephalus (Water on the brain)
 Sickle Cell Hemophilia Mental retardation Defects of spine (Spina Bifida)
 Stillborn birth Birth defects Polycystic kidney Chromosomal abnormalities

YOUR PAST MEDICAL HISTORY

	(Yes) (No)	(Yes) (No)	(Yes) (No)
Pelvic Infection	() ()	Diabetes	() ()
Mental Disorder	() ()	Thyroid Disease	() ()
Arthritis	() ()	Heart Disease	() ()
Rheumatic Fever	() ()	Drugs	() ()
Varicose Veins	() ()	Phlebitis	() ()
Asthma	() ()	Heart Murmur	() ()
Pneumonia	() ()	Seizures	() ()
Hepatitis	() ()	Kidney Disease	() ()
Ulcers	() ()	Kidney Infect.	() ()
		Sexually Transmitted Disease	() ()
		Liver or Gall Bladder Disease	() ()
		High Blood Pressure	() ()
		Breast Discharge or Mass	() ()
		Blood Disorder	() ()
		Blood Transfusion	() ()
		Broken Bones	() ()
		Sinus Headaches	() ()
		Migraine Headaches	() ()

Other medical conditions not listed: _____