Mercy Clinic Women's Health
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New Patient Questionnaire

Date:_____

Name: _____ Age:_____ Birthday:_____

Referred by: _____

Primary Care Physician: _____

How did you hear about us?_____

Please tell us why you are here:

_____
_____
_____
_____

Please list any **allergies** to medications or adverse reactions:

Medication name:	Reaction:	Comments:

Are you allergic to Latex? YES NO

Please list all **medications, vitamins** or **supplements** that you take daily or as needed:

Medication name and strength:	How frequently do you take it?	Why do you take it?

Please list your preferred **pharmacy** (name, closest intersection/location or phone number):

_____

Do you currently have, or have you ever had, the following **medical problems** (please circle all that apply):

Cancer: yes no Type:	Frequent bladder infections	Kidney disease
Abnormal pap smear	Herpes	MRSA
Anemia	Genital warts	Psychiatric problems:
Anesthesia problems	Gestational hypertension or preeclampsia	Lung disease
Anxiety	Gonorrhea	Seizures/epilepsy
Asthma	Heart disease	Sickle cell disease/trait
Autoimmune disease (lupus, rheumatoid arthritis, connective tissue disease)	Liver disease	Syphilis
Breast problems (not cancer)	Endometriosis	Tuberculosis or positive PPD
Chlamydia	HPV	Trichomonas
D (Rh) Sensitized	HIV/AIDS	Thyroid disease:
Depression	Hyperemesis (severe nausea/vomiting in pregnancy)	Trauma/violence
Diabetes	Blood pressure problems/hypertension	Uterine anomaly
Gestational diabetes	Infertility	Viral hepatitis
DVT/Pulmonary embolus	Irritable bowel syndrome	Chicken pox

Other:_____

Have you ever had any **procedures or surgeries**? Please circle all that apply:

No previous surgery	Gall bladder
Amniocentesis	Cryotherapy of the cervix (freezing cells)
Appendix	D & C
Infertility-related (IVF)	Hysterectomy: Vaginal Abdominal Laparoscopic
Blood transfusion	Removal of ovary(ies) (salpingoophorectomy)
Breast implants	Breast biopsy/lumpectomy
C-section	Myomectomy or removal of fibroids
Cervical cerclage	Tubal ligation
Cervical conization	Uterine surgery
Cystectomy (removal of ovarian cyst)	Diagnostic Laparoscopy
Tonsils and adenoids	Pace maker
Knee surgery	Heart surgery

Other: _____

Gynecological and Obstetrical History:

Last menstrual period:_____ Age of first period:_____ How often are your periods:_____

How long do your periods last:_____ Date of last PAP smear:_____

How many times total have you been pregnant?_____

How many children do you have?_____

How many miscarriages or abortions have you had?_____

Have you had any ectopic/tubal pregnancies?_____If yes, how many?_____

Have you had any forceps or vacuum-assisted deliveries? YES NO

Episiotomy or major tears? YES NO

Year of delivery:	Type of Delivery (vaginal or cesarean)	**How many weeks were you?**	**Boy/girl and birth weight**	**Complications**

In your **family**, does anyone have any of the following? Please circle all that apply:

Condition	**Who has it? (Mother, father, grandparents, siblings, children, aunts/ uncles, cousins)**
Diabetes	
High blood pressure	
Heart disease	
Stroke	
DVT/Pulmonary embolism	
Breast cancer	
Ovarian cancer	
Uterine cancer	
Colon cancer	
Other cancer	
Depression	
Thyroid disease	
High cholesterol or triglycerides	
Osteoporosis or fractures	
Endometriosis	
Fibroids	
Other:	

Social History:

Do you smoke tobacco? YES NO

If yes, how many cigarettes/day? _____ For how many years? _____

Do you drink alcoholic beverages? YES NO

How many drinks a week do you typically have? _____

Do you use any illicit drugs such as marijuana, cocaine, heroin, methamphetamines? YES NO

Are you sexually active? YES NO

Do you have sex with men, women or both? Please circle all that apply.

Do you feel safe in your relationship? YES NO

Have there been situations in your relationship where you have felt afraid? YES NO

Have you been physically hurt or threatened by your partner? YES NO

What birth control method do you currently use?

Condoms	Diaphragm/spermicide	Birth control pill	Patch or vaginal ring
Depo Provera shot	Intrauterine device (Mirena or Paragard)	Implanon	Surgical (tubal ligation or Essure)

Have you had any problems listed below? Please circle all that apply

Constitutional	Fever, chills, weight loss, weight gain, fatigue
Eyes, ear, nose, throat	Visual disturbances, earache, hearing loss, nasal congestion, postnasal drip, sore throat, snoring
Breast	Lumps, nipple discharge, tenderness, skin changes
Cardiovascular	Chest pain, chest tightness, palpitations, shortness of breath with exertion, irregular heartbeat, fatigue, ankle swelling
Gastrointestinal	Nausea, vomiting, bloating, diarrhea, constipation, blood in stool, black/tarry stools, changes in bowel habits, heartburn/reflux, painful swallowing
Genitourinary	Urinary frequency, urgency, incontinence, blood in urine, vaginal discharge, abnormal vaginal bleeding
Musculoskeletal	Muscle aches, neck pain, back pain, joint pain, joint swelling
Neurologic	Headaches, tremor, seizures, memory changes/loss
Psychiatric	Panic attacks, anxiety, depression, suicidal thoughts, behavioral problems, mood swings, PMS, history of abuse (verbal, sexual, emotional, physical)
Hematologic	Easy bruising, nose bleeds, gums bleeding, swollen lymph glands
Pulmonary	Cough, sputum production, shortness of breath, pleurisy, asthma attacks
Endocrine	Temperature intolerance, hot flashes, night sweats

Have you ever had the following?

	YES or NO	When was it last done (list the year if known)?
Gardasil vaccination series (3 shots total)		
Flu shot		
Mammogram		
Colonoscopy		
Bone Density Scan		