New Gynecology Patient Questionnaire Cover Sheet

Welcome to Overlake Reproductive Health! Please fill out the following form as completely as possible using Adobe reader. It is possible that there might be incompatibilities if you use another PDF program to fill out the forms. You may save your progress at any time. When you are done save the form in the following format “Firstname_Lastname GYN form” and email it to forms@fertileweb.com .You will receive a confirmation email within 2 business days of your email submittal. If you do not receive a confirmation email or if you have any questions/concerns about anything found on the form please contact the front desk at (425) 646-4700.

If you are a new patient please also fill out and submit the Front Office Paperwork found at http://fertileweb.com/patient-center/patient-forms/ . Please submit that form in the following format “Firstname_Lastname front office.” If we do not receive the paperwork at least **5 days before your first appointment** there is a chance that your appointment will have to be rescheduled to a later date.

We are looking forward to working with you!

Sincerely,

The ORH Staff

If you are experiencing any difficulties filling out the form please email Aaron@fertileweb.com

Patient Name _____

Please read the instructions on the cover sheet before submitting your questionnaire

Overlake Reproductive Health

NEW GYNECOLOGICAL PATIENT QUESTIONNAIRE

IDENTIFYING INFORMATION: Date: _____/____/____ (of first visit)

Name: _____

Age: _____ yrs Birth date: _____/____/____

Address: _____

City/State/Zip: _____

Telephone (day): (_____)_____ (evening): (_____)_____

Occupation: _____ Company: _____

Reason for visit: _____

_____

What are your expectations for this visit? _____

_____

What questions do you want answered at this visit? _____

_____

How did you hear about us ? (Please be as specific as possible)

☐ Physician

Name: _____ Phone: (_____)_____

Address: _____

☐ Former Patient/Friend:_____

☐ Website: _____ Advertisement: _____

☐ Insurance (Name of Insurance) _____

Who is your OB/GYN?

Name: _____Phone: (_____)_____

Address: _____

Who is your Primary Care Physician?

Name: _____Phone: (_____)_____

Address: _____

I. GYNECOLOGICAL HISTORY:
FEMALE: (Menstrual and Pregnancy history)

Total # of all pregnancies: _____

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

Date Pregnancy ended or delivered	Length of Pregnancy	How long to conceive	Result	Infertility Therapy?
1.	wks			
2.	wks			
3.	wks			
4.	wks			
5.	wks			

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

Explain: 1. _____

2. _____

3. _____

4. _____

Did you require? (circle pregnancies that apply):

C-section 1☐ 2☐ 3☐ 4☐ 5☐

Surgery 1☐ 2☐ 3☐ 4☐ 5☐

Blood transfusion 1☐ 2☐ 3☐ 4☐ 5☐

Antibiotics 1☐ 2☐ 3☐ 4☐ 5☐

D & C 1☐ 2☐ 3☐ 4☐ 5☐

Other 1☐ 2☐ 3☐ 4☐ 5☐

Explain: 1. _____

2. _____

3. _____

4. _____

Patient Name _____

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Age at first period _____yrs.

Age when you first noticed: Breast development ___yrs Pubic hair ___yrs Underarm hair ___yrs

Date of the first day of your last period _____/_____/_____

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next? _____

How many days does your menstrual flow last? _____

Do you consider your menstrual flow abnormal? Yes ☐ No ☐

light ☐ heavy ☐ short ☐ long ☐ painful ☐ other _____

Do you have severe cramping or pelvic pain with your periods?

Yes: ___ ☐ Always ___ ☐ Sometimes ___ ☐ Recently ___ ☐ In the past No ☐

Do you have pain with intercourse? Yes ☐ No ☐

Do you spot or bleed between periods? Yes ☐ No ☐

Do you have pelvic pain between periods? Yes ☐ No ☐

If it is a significant problem, please complete pelvic pain questionnaire)

Do you have premenstrual symptoms other than cramps? Yes ☐ No ☐

Do you need medication to bring on a period? Yes ☐ No ☐

Are your periods now, or have they ever been irregular or unpredictable? Yes ☐ No ☐

If yes:

1. When _____
2. Average # of periods in a year _____
3. Shortest time in between periods _____
4. Longest time spent without menstruating _____

(M.D. use only) _____

_____

_____

_____

_____

Do you have acne or oily skin? Yes ☐ No ☐

Do you have a breast discharge? Yes ☐ No ☐

Are you currently breast feeding? Yes ☐ No ☐

Do you have extra body hair? Yes: Where?_____ No ☐

What has been your maximum weight? _____ When? _____

What has been your minimum adult weight? _____ When? _____

Have you ever had a sudden weight change? Yes: When? _____ No ☐

Do you feel that you are underweight? Yes ☐ No ☐

Do you feel that you are overweight? Yes ☐ No ☐

How many meals do you usually eat per day? _____

Do you follow a particular food diet or have any special dietary habits? Yes ☐ No ☐

Have you ever been diagnosed with an eating disorder, such as anorexia or bulimia? Yes ☐ No ☐

Have you ever used self-induced vomiting to control overeating? Yes ☐ No ☐

Do you regularly participate in any vigorous exercise? Yes ☐ No ☐

What: _____

Number of hours _____/week Number of miles _____/week

FEMALE: (contraceptive history)

Have you ever taken oral contraceptives ("Pill")?

Name _____ From _____ To _____

Name _____ From _____ To _____

Name _____ From _____ To _____

Did you or your doctor note any problems? Yes ☐ No ☐

Explain _____

_____

Was it stopped because of a problem? Yes ☐ No ☐

Explain_____

_____

Were there any problems with your cycles after stopping the "pills"? Yes ☐ No ☐

Explain_____

_____

Have you ever used injectable contraception (Depo-Provera®, Lunelle ™ , etc.)?

Yes: Dates of use_____ Complications? _____ No ☐

Have you ever used an IUD? Yes ☐ No ☐

Name _____; From _____ To _____

Name _____; From _____ To _____

Did you note any problems? Yes ☐ No ☐

Pain☐ Bleeding☐ Fever ☐Infection ☐

Was it removed because of a problem? Yes ☐ No ☐

Explain_____

_____

Have you had tubal sterilization procedure (tubes tied)? Yes: _____ Date (mnth/yr) No ☐

If yes, have you had tubal reversal (tubes untied)? Yes: _____ Date (mnth/yr) No ☐

FEMALE: (Uterine, Tubal, Pelvic)

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

Yes (check all that apply) No ☐

☐ Chlamydia: date_____ ☐ Gonorrhea: date_____ ☐ Herpes: date_____ ☐ Genital warts/HPV: date_____

☐ Syphilis: date_____ ☐ HIV/AIDS: date _____ ☐ Hepatitis: date_____ ☐ Other_____: date_____

Have you had your appendix removed? Yes ☐ No ☐

Uncomplicated ☐ Ruptured ☐ Complicated ☐ Infection ☐

Did your mother take any hormones when she was pregnant with you? Yes ☐ No ☐

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? Yes ☐ No ☐

Explain: _____

_____

Have you ever had any of the following?

Procedure	Dates	Results
Endometrial Biopsy:		
Hysteroscopy:		
Laparoscopy:		
Tubal Surgery:		
Abdominal Surgery:		
Other Pelvic Surgery:		

Have you ever been noted to have or been treated for endometriosis? Yes ☐ No ☐

Treatment:_____

_____

II. FEMALE FAMILY HISTORY

Relative	Alive	Age
Mother _____	☐	_____
Father _____	☐	_____
Sisters/Brothers:		
☐ ☐ 1._____	☐	_____
☐ ☐ 2._____	☐	_____
☐ ☐ 3._____	☐	_____
☐ ☐ 4._____	☐	_____

Have any of your blood relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Bleeding disorders	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Bloodclots	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Excess hair growth	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐
Muscular dystrophy	☐	☐	☐	☐
Cystic fibrosis	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐
Physical retardation	☐	☐	☐	☐
Downs syndrome	☐	☐	☐	☐
Other chromosome defects	☐	☐	☐	☐
Frequent miscarriages	☐	☐	☐	☐
Stillbirths	☐	☐	☐	☐
Twins	☐	☐	☐	☐
Early menopause (before age 40)	☐	☐	☐	☐
Endometriosis	☐	☐	☐	☐
Infertility	☐	☐	☐	☐
Irregular periods	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Psychiatric problems	☐	☐	☐	☐

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel or ovarian cancer)? Yes☐ No☐

III. FEMALE MEDICAL HISTORY:

Do you have or have you ever had (circle all that apply):

☐ Scarlet fever
☐ Rheumatic fever
☐ Tuberculosis
☐ Hepatitis
☐ Heart murmur
☐ Pelvic infection
☐ Chicken pox
☐ Thyroid problems
☐ Cancer
☐ Kidney infection
☐ Heart disease
☐ High blood pressure
☐ Gallbladder problems
☐ Liver problems
☐ Ulcers
☐ Appendicitis
☐ Colitis
☐ Anemia
☐ Arthritis
☐ Breast lump
☐ Breast problems
☐ Breast discharge
☐ Neurological problems
☐ Seizures
☐ Epilepsy
☐ Dizziness
☐ Loss of balance
☐ Chronic headaches
☐ Vaginitis
☐ Pneumonia
☐ Parasites
☐ Ovarian cysts
☐ Other _____

Comments _____

_____

Patient Name _____

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PAP SMEAR HISTORY

When was your last pap smear? (month/year) _____/_____ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear? _____/_____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

Yes (check all that apply) ☐ No ☐

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram?

Yes - date _____ Result: ☐ normal ☐ abnormal - explain _____ No ☐

Do you perform breast self exams? Yes ☐ No ☐

Have you ever had Rubella (German measles)? Yes ☐ No ☐

Have you received Rubella immunization? Yes ☐ No ☐

Have you ever undergone surgery? Yes ☐ No ☐

Date	Type	Hospital

Were there:

Complications? Yes ☐ No ☐

Anesthesia problems? Yes ☐ No ☐

Bleeding problems? Yes ☐ No ☐

Comments _____

_____

_____

Are you allergic to any medication, drugs, foods, metals, other? Yes (list and describe reactions) No ☐

_____

_____

_____

Do you regularly take medications? Yes ☐ No ☐

1. Over the counter (list) Yes ☐ No ☐

   _____

2. Prescriptions (list) Yes ☐ No ☐

   _____

   _____

3. Are you taking any now (list) Yes ☐ No ☐

   _____

   _____

   _____

Do you use or have you ever used:

1. Alcohol, (# of glasses per week) Wine ____ Beer ____ Cocktails ____ Yes ☐ No ☐
2. Cigarettes, (present _____ prior _____) Yes ☐ No ☐

   # packs per day _____ # of years _____
3. Illicit or recreational drugs (specify) Yes ☐ No ☐

   _____

   _____ **Past** ☐ **Present** ☐

Patient Name _____

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COUPLE FACTORS (OPTIONAL)

How frequently do you have sexual intercourse?

- More than once a day ☐
- Daily or almost daily ☐
- 3-5 times a week ☐
- 1-2 time a week ☐
- Less than once a week ☐
- Irregularly ☐

Which of the following best describes how you feel about your sex life?

- Very satisfied ☐
- Fairly satisfied ☐
- Fairly unsatisfied ☐
- Very unsatisfied ☐

Which the following best describes how you think your partner feels about your mutual sex life?

- Very satisfied ☐
- Fairly satisfied ☐
- Fairly unsatisfied ☐
- Very unsatisfied ☐

Do any of these statements describe sex with your partner?

- It is sometimes difficult ☐
- It is almost always difficult ☐
- It is sometimes painful ☐
- It is almost always painful ☐
- It is sometimes unpleasant ☐
- It is almost always unpleasant ☐
- It is sometimes enjoyable ☐
- It is almost always enjoyable ☐

Do you or your partner have problems with initiating or completing sexual intercourse? Yes ☐ No ☐

Do you plan intercourse for a specific time of your cycle? Yes ☐ No ☐

When:_____

Do you use lubricant for intercourse? Yes ☐ No ☐

Do you douche before or after intercourse? Yes ☐ No ☐

Do you feel that your fertility problem is:

1. Causing personal stress Yes ☐ No ☐
2. Causing stress between you and your husband Yes ☐ No ☐
3. Interfering with a satisfactory sex life Yes ☐ No ☐

IV. REVIEW OF SYSTEMS

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack energy
- ☐ Fever/Chills
- ☐ Other _____
- ☐ none

Head, Eyes, Ears, Nose and Throat:
- ☐ Dizziness ☐ Loss of sense of smell
- ☐ Headaches ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other _____
- ☐ none

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other _____
- ☐ none

Endocrine/Hormonal
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance
  hot flashes or feeling cold
- ☐ Other _____
- ☐ none

Breasts:
- ☐ Discharge: clear ☐ bloody ☐ milky ☐
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants
  Saline ☐ Silicone ☐
- ☐ Other _____
- ☐ none

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other _____
- ☐ none

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other _____
- ☐ none

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other _____
- ☐ none

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other _____
- ☐ none

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other _____
- ☐ none

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle Cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons _____)
- ☐ Other _____
- ☐ none

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (need antibiotics before dental procedures? Yes ☐ No ☐)
- ☐ Other _____
- ☐ none

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other _____
- ☐ none

Physician Notes (for office use only) _____

_____

_____

_____

V. PHYSICAL EXAM:

Office Use Only

Height _____ Weight _____ Pulse _____ B.P. _____

Stature _____ Race _____

General Appearance: ☐Well developed ☐Well nourished ☐Normal mood/affect ☐Oriented x3 ☐No acute distress

Skin: ☐Acne ☐XS Sebum ☐Hirsuitism(facial,chest,back,areolar,abd.,thigh) ☐No lesions ☐No abnormal moles

Neck: ☐Supple ☐Without masses

Thyroid: ☐ WNL ☐No masses ☐Without thyromegaly

Breast: ☐No dominant masses ☐No skin changes ☐No nipple discharge

Lungs: ☐Clear to auscultation bilaterally ☐Normal respiratory effort

Heart: ☐Regular rhythm and rate ☐No murmurs/gallops

Abdomen: ☐Soft, non-distended ☐No masses/HSM ☐No hernias

Back: ☐No CVA tenderness

Lymphatic: ☐No neck ☐No axillary ☐No groin lymphadenopathy

Extremities: ☐Without varicosities ☐Without edema ☐Nontender calves

Pelvic Exam: ☐Normal external genitalia ☐Adnexa NT

Urethral meatus/urethra: ☐Without lesions, tenderness or prolapse

Bladder: ☐Without masses, tenderness ☐Well supported

Vagina: ☐Well supported ☐No lesions ☐No abnormal discharge

Cervix: ☐Without lesions ☐No CMT

Uterus Position: ☐Normal size & shape ☐Nontender ☐Without descent

Adnexa: ☐Normal size ☐No adnexal masses ☐No tenderness

Anus/Perineum: ☐No lesions

Rectal: ☐Normal sphincter tone ☐No hemorrhoids ☐No tenderness

Other Findings:

The above was discussed with the patient at the New Patient Consultation.

Signed: _____ Date: _____

F. IMPRESSION