

New Patient Questionnaire

Name: _____ Date: _____

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today? _____

Do you have any questions, problems, or concerns that you would like to discuss with us today?

What are your gender pronouns?

- She, her, hers, herself
- He, him, his, himself
- They, them, theirs, themselves
- Ze, hir, hers, himself
- Just my name, please
- Other _____

What is your ethnicity/ancestry?

- Ashkenazi Jewish
- Asian
- Black/African American
- French Canadian
- Hispanic/Latinx
- Mediterranean
- Native American or Alaska Native
- Pacific Islander or Native Hawaiian
- Sephardic Jewish
- White/Caucasian
- Other _____

Obstetric & Gynecologic History

Date of your last menstrual period _____

How often do you have a period? _____

Do you have any concerns about your period? _____

Do you use a method of contraception? Yes No

If yes, please indicate which type _____

Do you use it regularly? Yes No

Are you/your partner satisfied with this method? Yes No

Do you want any information about birth control? Yes No

Are you sexually active? _____

Date of your last Pap smear _____

Do you have a history of abnormal Pap smears? Yes No

Did you receive the HPV / Gardasil® vaccine? Yes No

Date of your last mammogram _____

Have you had an abnormal mammogram? Yes No

Have you had a breast biopsy or surgery? Yes No

Have you ever been pregnant? Yes No

Do you have any of the following health problems?

Asthma Yes No

High blood pressure Yes No

High cholesterol Yes No

Heart disease Yes No

Diabetes Yes No

Thyroid issues Yes No

Migraines Yes No

Anxiety Yes No

Depression Yes No

Postpartum depression Yes No

Other: _____

Have you ever had surgery? (If yes, please list.)

1. _____
2. _____
3. _____
4. _____
5. _____

What medications are you currently taking? (Please list each medication and your current dose.)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have allergies to any medications? Yes No

If yes, please list _____

Do you drink alcohol? Yes No

If yes, how many drinks per week? _____

Have you ever felt the need to cut down on drinking? Yes No

Do you smoke cigarettes or vape? Yes No

If yes, how many per day? _____

Do you use marijuana or recreational drugs? Yes No

If yes, please specify: _____

Are you exercising? Yes No

How often? _____

What type of exercise? _____

Do you have a family history of any of the following? (If yes, please list which family member)

- Breast cancer Yes No _____
- Ovarian cancer Yes No _____
- Uterine cancer Yes No _____
- Colon cancer Yes No _____
- Pancreatic cancer Yes No _____
- Melanoma Yes No _____
- High blood pressure Yes No _____
- High cholesterol Yes No _____
- Heart disease Yes No _____
- Diabetes Yes No _____
- Stroke Yes No _____
- Thyroid disorders Yes No _____
- Bleeding disorders Yes No _____
- Blood clotting disorders Yes No _____