

Dr. Gabrielson's New Patient Questionnaire

Date: _____

Name _____ DOB _____

Occupation _____ Employer _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Referred By _____

Primary Care Physician _____

Relationship Status (circle) S M W D Sep. Sig. Other

Partner's Name _____

Family History

If living (L), please indicate state of health. If deceased (D) please indicate cause of death.

Mother (age) _____ (L)____(D)

Sisters (ages) _____ (L)____(D)

Have any members of your immediate family had the following:

	NO	YES	RELATION
Cancer			
• Breast	_____	_____	_____
• Colon	_____	_____	_____
• Ovarian	_____	_____	_____
• Uterine	_____	_____	_____

Social History

Ht _____ Wt _____ Do you consider yourself overweight? _____

Allergies to Medications _____

List all of your medications _____

Do you smoke? _____ If yes, how much? _____

Do you use alcohol? _____ If yes, how often? _____

Do you use any recreational drugs? _____ If yes, what? _____

Past Medical History (do not include pregnancies)

Past Surgical History (do not include pregnancies)

Please circle the problems which apply to you:

- | | |
|------------------------|--------------------------------|
| Headaches | Chronic cough |
| Head injury | Food Allergies |
| Cataracts | Prolonged nausea/vomiting |
| Glaucoma | Diarrhea |
| Eye Pain/double vision | Change in bowel habits |
| Frequent ear infection | Blood in bowel movements |
| Loss of hearing | Hemorrhoids |
| Sinus infection | Abdominal pain |
| Nosebleeds | Gallbladder problems |
| Gums bleed easily | Jaundice (yellowing of skin) |
| Sores in mouth | Bruise easily |
| Thyroid disease | History of blood transfusion |
| Breast surgery | Burning/frequency of urination |
| Heart disease | Bladder/kidney infections |
| High Blood Pressure | Urine loss with cough/sneeze |
| Irregular heart beats | Arm or leg pain |
| Shortness of breath | Numbness/tingling |
| Heart murmur | Fainting |

Menstrual History

When was your first day of your last menstrual period? _____

How old were you when your menstrual periods began? _____

How long it is between your periods? _____

How many days does your period flow? _____

Do you have pain with your periods? _____

Do you have any pre-menstrual symptoms? _____

Do you have any symptoms of menopause? _____

Do you use tampons? _____ Do you use pads? _____

Are you sexually active? _____ Is your partner male or female? _____

Do you have pain or bleeding with intercourse? _____

Do you have sexual difficulty/discomfort in your relationship? _____

Have you ever been abused, threatened, or hurt by anyone? _____

Pap smear

-When was your last pap? _____

-Where was it done? _____

-Have you every had an abnormal? _____

-If so what was the treatment? _____

Breast

-Do you perform monthly self breast exams? _____

-Have you ever had a mammogram? _____

-If yes, when? _____

Have you ever been treat for (please circle if answer is yes):

- Vaginal infection Genital herpes Genital warts
- Chlamydia Other infections

Please circle any method of birth control you have used in the past:

- Birth Control Pills Diaphragm/Cervical Cap Intrauterine Device
- Sponge Foam(or other barrier method)

Condom
Tubal Ligation

Withdrawal
Vasectomy

Rhythm

What method do you use now? _____

Reproductive History

How many times have you been pregnant? _____

Have you ever had a (please give the year):

- Miscarriage _____
- Abortion _____
- Stillborn _____
- Premature birth _____

Have you ever been concerned about infertility? _____

Have you ever been tested for infertility? _____

Please list your births from oldest to youngest

Month/Year	Sex	Type of Delivery	Complications (Y/N)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What is your reason/concern/request for this visit?