SKYLANDS MEDICAL GROUP, P.A.
Obstetrics & Gynecology
New Patient Questionnaire

Patient Name: ______________________ Age: ________ Date: ____________

Reason for Visit: ______________________

Allergies to Medications: ______________________

Medical Problems: (check)

	No	Yes	Family Hx	Please Explain
Heart:	☐	☐	☐	______
Lungs:	☐	☐	☐	______
Seizures:	☐	☐	☐	______
Stroke:	☐	☐	☐	______
Thyroid:	☐	☐	☐	______
Blood Pressure:	☐	☐	☐	______
Diabetes:	☐	☐	☐	______
Cancer:	☐	☐	☐	______
Other:	☐	☐	☐	______

List all current medications: ______________________

List all previous surgeries/hospitalizations & dates: ______________________

Gynecological History

Type of birth control: ______________ Age of first period: __________

First date of last menstrual cycle: ______________ Average # of days: __________

Menstrual Cycles: (check one) ☐Regular ☐Irregular

Menstrual Flow: (check one) ☐Heavy ☐Moderate ☐Light

Menstrual Pain: (check one) ☐Severe ☐Moderate ☐Mild ☐None

Date of last PAP: ______________ ☐Normal ☐Abnormal

Have you ever had: (check if applicable) ☐ Herpes ☐ Syphilis ☐ Gonorrhea ☐ Pelvic Infection ☐ Chlamydia

Do you get frequent infections: (check if applicable) ☐ Urine ☐ Yeast ☐ Vaginal

Do you lose urine when coughing or sneezing: ☐Yes ☐No

If yes, explain: ______________________

Any pain with sexual relations: ☐Yes ☐No

Pregnancy History

Total # of pregnancies: ______________________ Twins: ________

Hepatitis: ☐Yes ☐No Infertility Problems: ☐Yes ☐No

Blood type: __________________ Blood Transfusions: ☐Yes ☐No

Do you: Smoke cigarettes: ☐Yes ☐No # per day: ______________

Take drugs: ☐Yes ☐No What kind(s): ______________________

Does anyone in your family have a birth or genetic defect: ☐Yes ☐No

If yes, explain: ____

Date	Weeks	Wt. Gain	Delivery Type	Birth Weight	Sex
					☐M ☐F
					☐M ☐F
					☐M ☐F
					☐M ☐F

Complications: ____

Gastrointestinal History

Nausea/Vomiting: ☐Yes ☐No Diarrhea: ☐Yes ☐No

Constipation: ☐Yes ☐No Gallbladder: ☐Yes ☐No

Medical Diseases/Disorders

Mitral Valve Prolapse: ☐Yes ☐No Asthma: ☐Yes ☐No

Rheumatic Fever: ☐Yes ☐No Colitis: ☐Yes ☐No

Cancer: ☐Yes ☐No Lupus: ☐Yes ☐No

Other: ____

Additional Comments: ____

____

Patient Signature: ____

Reviewed by: ____