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

Date of last Mammogram: _____ ☐Normal ☐Abnormal

Hysterectomy: ☐Yes ☐No

Print Form

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: _____