New England OB-GYN Health Questionnaire and Update

Patient Name: ______________________________________ **DOB:** __________________

Physician Name: ______________________________________ **Date:** __________________

Main reason for visit today: ☐ Annual ☐ Problem

Section 1 (Problem Visit Only) - Chief Complaint:

Please describe the problem:

On a scale of 1-10, with 10 being the most severe, circle the number that best describes this problem:

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

Does anything help or make the problem worse?

How long does the problem last?

Is anything else occurring at the same time?

Is the problem constant or variable?

Does the problem interfere with your daily functions?

☐ Yes ☐ No Explain:

ALL PATIENTS COMPLETE THE FOLLOWING SECTIONS

MEDICARE "HIGH RISK" CRITERIA: Please check (√) if you have ever been treated for any of the following infections:

Vaginosis/BV	☐	Genital Warts	☐	Chlamydia	☐
Trichomonas	☐	Gonorrhea	☐	Syphilis	☐

	Yes	No	
Did your mother take the drug DES when she was pregnant with you?	☐	☐	
Have you ever had an abnormal Pap smear test?	☐	☐	If so, when? ___
Did you begin sexual activity before you were 16 years old?	☐	☐	
Have you had more than 5 sexual partners in your lifetime?	☐	☐	
Have you ever tested positive for the AIDS/Human Immunodeficiency Virus (HIV)	☐	☐	
Have you had a Pap smear in the last 7 years?	☐	☐	

PERSONAL SAFETY - We routinely ask patients about their safety because abuse can have a serious impact on health and well-being.

Current Partner(s) ☐ No Current Partner ☐ Decline ☐

Are you currently or in the past 12 months have you been in a relationship with a person who physically hurts, threatens, or tries to control you? Yes ☐ No ☐

Has anyone else in your life physically hurt, threatened or tries to control you? Yes ☐ No ☐

Are you denied basic needs such as food, clothing, or medical care? Yes ☐ No ☐

PLEASE PROVIDER AN UPDATE SINCE YOUR LAST VISIT

Has there been a change in your periods? Y / N Describe ______________________________

Date of your last period Month/Year ______________________________

Do you use a method of contraception? Y / N Type ______________________________

Do you have any questions about safer sex? Y / N Question ______________________________

Date of your last pap smear Month/Year/Result ______________________________

Date of last mammogram Month/Year ______________________________

Do you smoke cigarettes? Y / N Packs/Day ______________________________

Do you use illicit drugs? Y / N Drinks/Day ______________________________

Do you drink alcohol? Y / N Amount ______________________________

Do you exercise regularly? Y / N Describe______________________________

Any recent illnesses? Y / N Describe______________________________

Have you seen any other doctors recently? Y / N List names/Reason ______________________________

Have you had a cholesterol tests? Y / N Result ______________________________

Have you had any other tests? Y / N Result ______________________________

Update family history? Mother ______________________________

Father ______________________________

Sibling ______________________________

Any changes in occupation, problems at home, or changes in relationships? Y/N

Do you have any questions or concerns you would like to discuss at this visit? Y/N

Patient Signature ____ Date ____________