New England OB-GYN Health Questionnaire and Update Patient

Name:____ **DOB:** ______________

Physician Name: ____________________________________ **Date:** ______________

Are you experiencing a problem?
Please describe the problem:

____

____

____

____

When did the problem start?

____

Does anything help or make the problem worse?

____

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

Review of Systems
Any complaints:

Eyes/Nose/Throat? Y/N ___________________________

Respiratory? Y/N ___________________________

Cardiovascular? Y/N ___________________________

Back/joint pain? Y/N ___________________________

Skin? Y/N ___________________________

Dizziness/headaches? Y/N ___________________________

Allergies? Y/N ___________________________

Anxiety/Depression? Y/N ___________________________

Abdominal pain/bloating? Y/N _______________________

Nausea/vomiting? Y/N ___________________________

Fever/chills? Y/N ___________________________

Fatigue? Y/N ___________________________

Weight change? Y/N ___________________________

Genitourinary:

- Pain? Y/N ___________________________
- Urinary Issue? Y/N _________________________
- Bleeding? Y/N _________________________
- Discharge? Y/N ___________________________
- Sores? Y/N ___________________________
- Menopause symptom? Y/N ___________________

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	☐

Please answering the following questions:	**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 ☐

	Yes	**No**
Are you currently in or in the past 12 months have you been in a relationship with a person who physically hurts, threatens, or tries to control you?	☐	☐
Has anyone else in your life physical hurt, threatened, or tried to control you?	☐	☐
Are you denied basic needs such as food, clothing, or medical care?	☐	☐

PLEASE PROVIDE AN UPDATE SINCE YOUR LAST VISIT

Has there been a change in your periods?	Y / N	Describe ____________________
Date of your last period		Day/Month/Year ____________________
Are you currently sexually active?	Y / N	Partners: Male/Female/Both
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 ____________________
Update family history?		Mother ____________________
		Father ____________________
		Sibling ____________________

Any changes in occupation, problems at home, or changes in relationships?

____

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

____

____

Patient Signature ______________________________ Date ____________