Ahmet Helvacioglu M.D. *Gynecology & Infertility Associates*

New Patient Medical Questionnaire

Date: ________________ Name: ____

Date of Birth: _________________________ Age: ____ Referred By: ________________________

Reasons for this Visit/Complaints:

1. ____
2. ____
3. ____
4. ____

Tests: Have you had any one of these tests listed below? Please list the most recent and date.

Mammogram:	Pap Smear:
Bone Density:	GYN Exam
Pelvic Ultrasound:	Lipid Panel:
Colonoscopy:	Polyps? Yes or No

Bone Health: Have you ever been diagnosed with: Osteoporosis, Yes No Osteopenia, Yes No
Have you broken any bones? Yes or No Which bone/s ____
How did it happen? ____
Do you take Calcium? Yes or No Vitamin D? Yes or No Which kind and how often? ____________________
Do you take any bone medications such as Fosamax, Boniva, Actonel, Evista, or other? How long?___________

History of Periods: How old where you when you started your period? ___________
Are you in <u>menopause</u>? Yes or No At what age?______If, *yes,* go to the next section (history of sex)
<u>First</u> day of <u>last</u> menstrual bleeding: ___/___/___.
If this bleeding was **NOT** normal, when was the first day of your last normal period? ___/___/___.
Do you have regular periods? Yes or No
Do you bleed heavy? Yes or No
How often do you bleed? (from first day of bleeding to the first day of your next bleeding) Every ____days.
How many days do you bleed? ____days. Are they painful? Yes or No: If yes, severe, moderate or mild.

Pregnancies: Did you or do you have a difficult time getting pregnant? Yes or No
Total number of: pregnancies _____ vaginal delivery _____ C-section_____ abortions_____
miscarriages_____ adoptions ______ living children_____

History of Sex:
Are you currently sexually active? Yes or No
If no, when was the last time you had sex? __months __years ago.
If yes, do you use any kind of birth control? Yes or No
If yes, which type of birth control: Tubal ligation, hysterectomy, partner had vasectomy, birth control pill, IUD, Depo Provera injections, condom, ring, patch, implant, vaginal spermicides, other _____________.

History of Bladder: Do you have problems holding urine? Yes, No, Sometimes, Rare.
If no, go to next section (history of bowel)
Do you wet yourself when you sneeze, cough, or laugh? Yes, No, Sometime, Rare
Do you have urgency to urinate? Yes, No, Sometimes, Rare
Do you wet yourself because you could not make it to the bathroom on time? Yes, No, Sometimes, Rare
Do you have urinary frequency? Yes, No, Sometimes, Rare
Do you use pads? Yes or No
Do you lose urine without feeling it? Yes or No

History of Bowel: Do you have problem controlling bowel movements (soiling yourself)? Yes or No
Do you have regular bowel movements? Yes or No If no, please explain______________________________
____

Hormones: Do you have hot flashes? Yes or No Do you get night sweats? Yes or No
Do you take hormones? Yes or No What kind? ________________ Dose____________________
How often? Daily, Weekly, Twice Weekly, Monthly, Every 3 months? How long have you been using? _______

Hospital Admissions: Have you ever been hospitalized for non-surgical reasons? If so please list the dates, locations and reasons:
____
____
____
____
____

Surgical:

Surgery	Date	Hospital / Surgeon
1.		
2.		
3.		
4.		
5.		
6.		

Have you ever had anesthesia complications? Yes or No
Are you against receiving blood transfusions? Yes or No

Current Medications: Please include over-the-counter medications and dietary supplements. Please list the name of the medication, dose and how long you have been taking the medicine:

1.
2.
3.
4.
5.
6.

Are you currently using or in the past have used any of the following:(circle)
Xanax Valium Lorazepam Librium Lortab Percocet Vicodin Morphine
Any other prescription pain killers or sleeping pills for longer than one month? ___________________
Reason: (circle) Back Pain Depression Insomnia Other type of pain Addiction

Allergies: (circle) If answer is yes, list the names of the drug, food or reason for the allergy.
Drug / Medication Yes No ______________________________

Food Yes No ______________________________
Environmental Yes No ______________________________

Marital Status (Circle): Married Single Divorced Separated Widowed
Times Married? ____________ Spouse's Name and DOB:______________________________
Education: ______________________________ Profession: ______________________________
Work Place: ____________________________ Position: ______________________________

Habits: (circle) TOBACCO: Yes No If yes, ____ packs per day for ____years. Quit____months/years ago
ALCOHOL: Yes No If yes: Wine Beer Liquor, ____oz, ____times a week, Rarely
PRESCRIPTION PAIN KILLERS: Yes No
NON PRESPCRIPTION / STREET DRUGS: Yes No

Exercise: Do you exercise? Yes No Sometimes What type? ______________________________
How often? ____________________ each exercise session lasts ________________minutes.

Medical: Do you have or have had any the following (circle):

Diabetes	Diabetes(insulin dependent)	High blood pressure	Elevated cholesterol
Stroke	Heart attack	Or other heart conditions:	________________________
Bleeding problems	Clotting problems	Blood clots in lungs	Blood clots in legs (DVT)
Seizure Disorder	Headaches	Migraines	Depression
Anxiety	Bipolar	ADD	Sleep problems
Sleep apnea	Snoring	Or other Psychiatric disease:	________________________
Thyroid problems	Asthma	Blood transfusion	Anemia
Hepatitis	Liver disease	Kidney disease	Kidney stones
IBS	Diverticular disease	Crohn's disease	GERD
Stomach ulcers	Colon polyps	Indigestion	Rheumatoid arthritis
Fibromyalgia	Chronic back pain	Bone fracture	Degenerative disk disease
Hearing problems	Vision problems	Poor memory	

Cancer: Date diagnosed:_____________________ What kind: ______________________________
Other medical problems not mentioned above: ______________________________
____
____
____

Are you disabled? Yes or No What is the nature of the disability?
____

Have you ever been hospitalized for psychiatric / mental problems? If so, please list the dates, locations and reasons:
____
____

Family History: List the blood relatives who have or have had. Please state if *maternal* or *paternal*, MGM for maternal grandmother, PGF for paternal grandfather, etc.

Colon Cancer:	Breast Cancer:
Ovarian Cancer:	Lung Cancer:
Other Cancer: (who and type)	

Diabetes:	Rheumatoid Arthritis:
High Blood Pressure:	Thyroid Problems:
Heart Condition	Liver Disease:
Stroke:	Kidney Diseases:
Bleeding Problems:	Depression or Psychiatric illness:
High Cholesterol:	Osteoporosis:
Heart Attack:	Other:

Has any family member died of a heart attack or stroke under the age of 50? Who? _____ age? ________
Is Mother alive? Yes No Age now or at death:______________________
Is Father alive? Yes No Age now or at death:______________________

Vaccinations: HPV/Gardasil? Yes or No If yes, is the series complete? Yes or No
Influenza this year? Yes or No Pneumococcal? Yes or No When?__ Td/Tdap? Yes or No When?____
Zoster/Shingles? Yes or No

Name of your previous OB/GYN: ________________________________
Name of Primary Care Physician: ________________________________

Patient Signature: ___________________________________Date:_________