

Gynecology New Patient Questionnaire

Preferred Name: _____ Age: ____ LMP (1st day): _____

Reason for visit: _____

These questions cover important gynecological issues for all women. We strongly encourage everyone to have a Primary Care Physician to cover other health issues.

What is your gender identity: _____ Pronouns: She/her He/him They/them

Over the past 2 weeks, how often have you been bothered by any of the following: *(Please x response)*

	0- Not at all	1- Several days	2- More than ½ the days	3- Nearly every day
1. little interest or pleasure in doing things				
2. feeling down, depressed, or hopeless				

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? No Yes

Do you feel unsafe in your current relationship? No Yes

Is there a partner from a previous relationship who is making you feel unsafe now? No Yes

ALLERGIES

Do you have any food allergies? No Yes *(please list)* _____

Please list any medication or drug allergies you have below: None

Drug Name	Reaction

MEDICATIONS

List any prescribed medications you are taking, including contraception. Need refills?

Medication Name	Dose/Strength	How do you take it?	Refill
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Please list any non-prescribed or over the counter medications you are taking: None

CONTRACEPTION *(Skip section if no longer having periods)* Current birth control method? _____

Do you want to change? ___ No ___ Yes Thinking of conceiving in the next year? ___ No ___ Yes

Clinic Use Only: Height _____ Weight _____ BP _____

Orders: Pap smear Mammogram DXA STI CT/GC Labs Immunization _____ Referral

MENSTRUAL HISTORY

Still having periods, please answer the following:

What age did your periods begin: _____ Length of period (days): _____ Number of days between periods _____
Are your periods? ___ Painful (cramps) ___ Heavy. Cause you to miss work or activities? ___No ___Yes

No longer having periods, please answer the following: At what age did you stop having periods? _____

Have you had a hysterectomy? ___ No ___ Yes, what year? _____

Were your ovaries removed? ___No ___Yes Was your cervix removed? ___No ___Yes

Are you taking or have you taken hormone therapy? ___ No ___ Yes, in the past ___ Yes, currently taking

PREVENTATIVE HEALTH HISTORY

Have you had a blood test for Hepatitis C? No Yes Unsure/Unknown

12 years of age and older Have you had the Human Papilloma Virus Immunization (Gardasil)? No Yes

21 years of age and older: Date of your last Pap Smear _____ Was it normal? No Yes

Have you had an abnormal pap? No Yes Year? _____ Colposcopy for abnormal pap smear? No Yes,
Treatment for abnormal pap smear? No Yes, Treatment Performed: Cryotherapy LEEP Cone Biopsy

40 years of age and older: Date of your last Mammogram _____ Location _____ N/A

Do you perform regular breast self-examinations? No Yes

45 years of age or older Date of your last Colonoscopy, Cologuard, or Stool Hemocult (circle)
_____ N/A

65 years of age or older Date of your last DEXA (bone density scan) _____ N/A

GYNECOLOGICAL HISTORY- Check all that apply for past or present conditions None

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal pap smear/HPV | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Pelvic / Tubal Infection |
| <input type="checkbox"/> Abnormal pap smear treatment | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polycystic Ovary Syndrome |
| <input type="checkbox"/> Abnormal Uterine Bleeding | <input type="checkbox"/> Gynecological Cancer | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> DES Exposure | <input type="checkbox"/> Infertility | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian Cysts | |

MEDICAL HISTORY

MEDICAL CONDITIONS YOU HAVE OR HAVE HAD: None

SURGERIES (PLEASE INCLUDE MONTH/YEAR): None

SOCIAL HISTORY

Do you currently use tobacco products? No Yes, are you ready to quit? ___ No ___ Yes

How often do you use:

- | | | | |
|---------------------|--------------------------------|--|--|
| Tobacco? | <input type="checkbox"/> Never | <input type="checkbox"/> Current/daily | <input type="checkbox"/> Former year quit: _____ |
| E-Cigarette? | <input type="checkbox"/> Never | <input type="checkbox"/> Current/daily | <input type="checkbox"/> Former year quit: _____ |
| Smokeless Tobacco? | <input type="checkbox"/> Never | <input type="checkbox"/> Current/daily | <input type="checkbox"/> Former year quit: _____ |
| Alcohol? | <input type="checkbox"/> Never | <input type="checkbox"/> Current/daily | <input type="checkbox"/> Socially <input type="checkbox"/> Former year quit: _____ |
| Recreational Drugs? | <input type="checkbox"/> Never | <input type="checkbox"/> Current/daily | <input type="checkbox"/> Former year quit: _____ |

Occupation: _____ Relationship Status: _____ Partner's name: _____

SEXUAL HEALTH

Are you sexually active? ___ No ___ Yes Partners: ___ Male ___ Female
 More than one partner this year? ___ No ___ Yes Do you have problems with intercourse? ___ No ___ Yes
FAMILY HISTORY Are you adopted? ___ No ___ Yes

Please list immediate family members (1st degree) who have:

Breast Cancer _____ Colon Cancer _____
 Ovarian Cancer _____ Other Cancer _____

Relationship	Name	Status/Age	List any/all Medical Conditions
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Other			
Other			

PREGNANCY HISTORY

How many times have you been pregnant? _____ How many children are living? _____ #Twin pregnancies? _____
 #Vaginal delivery _____ #Cesarean Section _____ #VBAC _____ #Miscarriage _____ #Abortion _____ #Ectopic _____
 If you had a miscarriage or abortion, did you take pills or have a D&C procedure? ___ No ___ Yes, which _____

Month/Year	Birth Weight	Gender	Weeks Pregnant	Type of Birth	Complications

Have you had other health screenings this year? *Please list:*

Please list your primary care physician and other current health care providers you have with their specialty:

If completing form by computer, please save your responses and send us a MyHealth message and attach the file (PDF only). Otherwise please return completed form to the receptionist. Thank you.

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