

NEW PATIENT QUESTIONNAIRE

The location of your appointment is: Franciscan Physician Network - Obstetrics & Gynecology - Lafayette
 3920 St Francis Way, Lafayette IN 47905

Franciscan Physician Network - Obstetrics & Gynecology - Crawfordsville
 1630 Lafayette Road, Suite 400, Crawfordsville IN 47933

Thank you for selecting us to take part in your medical care. We always strive to give the best care possible. It would help us if you would complete this questionnaire prior to your appointment. The information contained in here will be kept strictly confidential and will not be released to anyone without your written authorization. If you have any questions, don't hesitate to contact our office. **Please arrive 15 minutes before your scheduled appointment.** We look forward to seeing you.

Name: _____ Birthdate: _____

Date of appointment: _____ with Physician/Nurse Practitioner: _____

What is (are) your primary reasons for this appointment?

PROBLEM	HOW LONG PRESENT	WHAT YOU HAVE TRIED

MENSTRUAL HISTORY

IF NOT POST-MENOPAUSAL (if still having periods):

1. Age first period began: _____

2. First day of last menstrual period: _____

3. Was it a normal period?..... YES NO

4. Are your periods regular?..... YES NO

5. Do you have any bleeding between periods?..... YES NO

6. Is cramping a problem?..... YES NO

If yes, what have you tried for the cramps:

Name of medication: _____ strength: _____

How often: _____ how successful is treatment: _____

7. How many days usually pass from the start of one period to the start of the next? _____

8. How long do your periods last? _____

9. On the heaviest day, how often do you have to change a pad or tampon because is it soaked? Every _____

--	--	--	--	--	--	--	--	--	--

Name: _____ DOB: _____

PAST MEDICAL HISTORY

Hospitalizations and surgeries:

DATE	WHERE	DIAGNOSIS AND/OR PROCEDURE	COMMENTS

MEDICAL HISTORY: DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING:

	YES	NO	COMMENTS
1. Severe or migraine headaches			
2. Thyroid problems			
3. Heart murmur			
4. Other heart problems			
5. Cholesterol checked			When? Results
6. Asthma			
7. Other lung problems			
8. High blood pressure			
9. Diabetes			
10. Blood transfusions			When?
11. Blood clots in legs or lungs			
12. Phlebitis			
13. Varicose veins			
14. "Colitis", irritable bowel or spastic colon			
15. Other bowel problems			
16. Liver problems (eg hepatitis)			
17. Gallstones			
18. Kidney stones			
19. Seizures, epilepsy, or convulsions			
20. Stroke			
21. Nervous breakdown			
22. Severe depression			
23. Panic attacks			
24. Other nervous or mental disorders			
25. Breast cancer			
26. Endometrial (uterine lining) cancer			
27. Endometriosis			
28. Pelvic infection, tubal infection, PID (pelvic inflammatory disease)			
29. Genital herpes			
30. Genital warts			
31. Gonorrhea			
32. Chlamydia			
33. Syphilis			

34. AIDS or positive HIV test			
35. Birth defects or any inherited disease			

Name: _____ DOB: _____

CONT'D	YES	NO	COMMENTS
36. Measles or the vaccine			
37. German measles (Rubella) or the vaccine			When?
38. Chicken pox			
39. Tetanus booster			When?
40. Human Papilloma vaccine (HPV)			When?
41. Colonoscopy			When?
42. Bone Densitometry Scan			When?
43. Other health problems			

MEDICATIONS

(include prescription, nonprescription, and herbal)

NAME	STRENGTH	HOW OFTEN TAKEN	PRESCRIBING DOCTOR (if any)	REASON FOR TAKING

List medications you cannot take for any reasons (eg allergies):

NAME OF MEDICATION	REACTION

FAMILY HISTORY

Please list, if any, blood relatives that have any of the following problems:

HEALTH PROBLEMS	RELATIONSHIP TO YOU (mother, sister, ect.)	HOW OLD THEY WERE WHEN DIAGNOSED
Breast cancer		
Ovarian cancer		
Colon cancer		
Other cancer (type)		
Osteoporosis (broken hip or wrist, collapsed vertebra, or "Dowager's hump")		
Diabetes		
Heart attacks		
Stroke		
High cholesterol		
Other (eg genetic disease such as hemophilia, other inherited bleeding tendencies, cystic fibrosis, muscular dystrophy,		

inherited anemia, etc)		
------------------------	--	--

Name: _____ DOB: _____

REVIEW OF SYSTEMS: Have you recently been troubled with any of the following:

	YES	NO		YES	NO
GENERAL HEALTH:			GENITOURINARY:		
Unexplained weight loss			Pain with urination		
Unexplained weight gain			Blood in urine		
Fever			Frequent urination		
Fatigue			Urine loss with strong urge to void		
Hot flashes			Urine loss with cough/sneeze/laugh		
			Incomplete emptying of bladder		
EARS/NOSE/MOUTH/THROAT:			Pain with or after sex		
Unusual or frequent headaches			Bleeding with sex		
Hearing loss			Vaginal dryness with intercourse		
Ringing in ears			Low sex drive		
			Abnormal vaginal discharge		
EYES:			Vaginal itching and/or burning		
Visual changes			Foul vaginal odor		
BREAST:			MUSCULOSKELETAL:		
Mass/lump in breast(s)			Weak muscles		
Nipple discharge			Joint pain		
			Back pain		
CARDIOVASCULAR:					
Chest pains			SKIN:		
Palpitations			Changing or new moles		
RESPIRATORY:			NEUROLOGIC:		
Wheezing			Faintness		
Cough up blood			Numbness or tingling in legs or arms		
Persistent cough					
Difficulty breathing			PSYCHIATRIC:		
			Severe anxiety		
GASTROINTESTINAL:			Depressed feeling		
Diarrhea			Crying spells		
Blood in stools			Feel like committing suicide		
Constipation (infreq and/or hard stools)					
Stomach and/or pelvic pain			ENDOCRINE:		
Fecal incontinence			Excessive thirst		
Nausea			Heat intolerance		
Vomiting			Cold intolerance		
Abdominal enlargement			Excessive hair growth (ie face)		
Indigestion					
Loss of appetite			LYMPHATIC/BLOOD:		
			Excessive bleeding when cut		
			Easy bruising		
			Swollen lymph nodes or glands		

Name: _____ DOB: _____

SENSITIVE QUESTIONS:

As with the rest of the questionnaire, all these questions are strictly confidential and used only to help care for your health. You do not have to answer any questions that make you uncomfortable.

- 1) Have you ever used any street drugs?.....YES NO
(This is strictly confidential and for health care purposes only)
If yes, please list below:

TYPE OF DRUG	HOW USED (smoke, "snort", "shoot up")	HOW MUCH	HOW OFTEN	LAST USED

- 2) Have you ever been forced or coerced into having sex against your will?.....YES NO

- 3) Have you ever been physically abused?.....YES NO

- 4) Have you ever had sexual intercourse?.....YES NO

If yes, how many sexual partners have you had in your life? _____

- 5) Are you currently sexually active?.....YES NO

If no, when did you last have sexual intercourse? _____

If yes, how long have you been with your current sexual partner? _____

- 6) Do you believe your current sexual relationship has been monogamous (you have sex only with your partner and they have sex only with you)?.....YES NO

Last revision: 8-18-2016