

BAYSIDE WOMEN'S HEALTH

Obstetrics & Gynecology

Dr. Beverley Savage

Dr. Peter Brown

NEW PATIENT QUESTIONNAIRE

NAME:

DATE:

Present Symptoms

Current Symptoms (check any that apply)	General	Weight loss Weight gain Fever Night sweats
	Eyes	Double vision Tearing Blind spots Eye pain
	Ears/Nose/Mouth/ Throat	Headaches Dizziness Lightheadedness Nose bleeding Nasal obstruction Dental difficulties Bleeding gums Dentures Neck stiffness Neck pain Neck tenderness Neck mass
	Cardiovascular	Chest pain Irregular heart beat Fainting Shortness of breath with exertion Shortness of breath lying down Shortness of breath when waking at night Swelling High blood pressure Heart murmur Varicosities Phlebitis Painful extremity with movement
	Respiratory	Wheezing Cough Coughing blood Respiratory infections Tuberculosis Pain with deep inspiration Bronchitis Pneumonia
	Gastrointestinal	Poor appetite Difficulty swallowing Indigestion Abdominal pain Heartburn Nausea Vomiting Vomiting blood Yellow skin Constipation Diarrhea Abnormal stools Flatulence Hemorrhoids Recent changes in bowel habits Blood in stools
	Genitourinary	Urgency Frequency Painful urination Getting up at night to urinate Blood in Urine Frequent urination Lack of urine Stones Urinary infections Kidney infections Vaginal discharge Venereal disease Urinary incontinence Abnormal vaginal bleeding Pelvic pain Pain with intercourse Vaginal dryness Irregular periods Pain with periods Heavy periods
	Musculoskeletal	Joint pain Limitation of motion Muscular weakness Muscle cramps
	Skin/Breast	Rash Itching Pigmentation Changes in hair growth or loss Nail changes Breast lumps Breast tenderness Breast swelling Nipple discharge
	Neurologic	Convulsions Paralysis Tremor Incoordination Difficulties with memory or speech Sensory or motor disturbances Problem with muscular coordination
	Emotional	Nervousness Emotional problems Anxiety Depression Difficulty sleeping Previous psychiatric care Hallucinations
	Endocrine	Increased water intake Hormone therapy Abnormal growth Excessive thirst Intolerance to heat or cold

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	Hematology/ Lymphatic	Anemia reactions Bleeding tendency Rh incompatibility Previous transfusions and Lymph node enlargement or tenderness
	Allergic/ Immunologic	Reactions to drugs Reaction to food Reaction to insects
	OTHER SYMPTOMS:	

Past Surgeries w/dates: _____

Past Diseases or Illnesses: _____

Present

Medications: _____

Family History of: Heart Disease Cancer Hypertension Diabetes Other illnesses (please list)

Allergies: _____

Main Reason for Today's Visit: _____

Gynecologic History:

First day last menses: _____ # of days between periods: _____ #of bleeding days _____

Pads or tampons used per day: _____ How many pregnancies? _____

Number of living children _____ Date of last pregnancy _____

Plans for pregnancy this year? Yes No What do you use for birth control? _____

Date of last PAP smear _____

Last mammogram: _____ Last osteoporosis screen: _____

Last screen for colon cancer: _____

Last cholesterol screen: _____

Health habits:

Height: _____ Weight: _____ Do you smoke? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you drink caffeine? Yes No If yes, how much? _____

Do you use marijuana, cocaine or other street drugs? Yes No If yes, which ones _____

Do you wear seatbelts? _____

Do you get calcium in your diet? Yes No How? _____

How often do you exercise? _____ For how long at a time? _____

What type of exercise? _____

Do you do self breast exams? _____

Are there any problems or issues that you would like to discuss today? _____

Physician signature _____