OFFICE USE ONLY:
DR._____

Wt._____ Ht._____

BP_____

Lakeside Doctors
Gynecology & Obstetrics

New Patient Form

Please use **BLACK INK only**

Patient Questionnaire

1. Name_____ Date _____

2. Reason for this visit: _____

3. Referring Physician: _____ **4.** How did you hear about us? _____

5. Preferred phone number: _____

6. Pharmacy Address: _____ Pharmacy Phone: _____

7. Primary Care Physician: _____ Address: _____ Phone: _____

Current Medications (Please list all medications, vitamins and supplements.)

Medication	Dose	Frequency

Are you allergic to any medications? ☐ No ☐ Yes

List Medicine and Reaction: _____

Vaccine History

TDAP	☐ NO	☐ YES	If yes, Date of Vaccination: _____
COVID	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Pneumonia	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Gardasil (HPV)	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Shingles	☐ NO	☐ YES	If yes, Date of Vaccination: _____
Flu	☐ NO	☐ YES	If yes, Date of Vaccination: _____

Gynecological History

1. Age of first period_____ **2.** Do you have cramps? ☐ NO ☐ YES

3. If your menstrual periods are regular; periods start every _____ days

4. If your menstrual periods are irregular; periods start every _____ to_____ days (e.g., 12 to 60)

5. First day of last menstrual period: _____ (m/d/year) **6.** Is your period flow: ☐ Light ☐ Moderate ☐ Heavy

7. If postmenopausal, at what age? _____

Pap Smear/ Mammogram/ Bone Density/ Colonoscopy History

1. Date of last pap smear: _____ **2.** Have you had treatment for abnormal smears? ☐ NO ☐ YES

3. Have you had any of the following for abnormal paps:

Cryotherapy? If so, when? _____ Laser? If so, when? _____

Cone Biopsy? If so, when? _____ Loop Excision (LEEP)? If so, when? _____

4. Have you had a Mammogram? ☐ NO ☐ YES Date: _____Result: _____Location:_____

5. Have you had a Bone Density: ☐ NO ☐ YES Date: _____Result: _____Location: _____

6. Have you had a Colonoscopy? ☐ NO ☐ YES Date: _____Result: _____Location: _____

Pregnancy History (All pregnancies) **Have never been pregnant** ☐

OBSTETRICAL HISTORY INCLUDING MISCARRIAGES, ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

# of pregnancies:	**# of full term births:**	**# of pre-term births:**	**# of pregnancy losses:**	**# of living children:**	**# of induced abortions:**

Date of Delivery	Place of delivery	Duration Pregnancy	Type of Delivery Vaginal or C-Section	Complications Mother/Infant	Child's Sex	Birth Weight	Present Health

Family History

Illness	**Relation**	**Maternal**	**Paternal**	**Illness**	**Relation**	**Maternal**	**Paternal**
1. AIDS (HIV)	_____	☐	☐	**11.** High Blood Pressure	_____	☐	☐
2. Anemia/ Blood Disorder	_____	☐	☐	**12.** High Colesterol	_____	☐	☐
3. Anesthesia Complications	_____	☐	☐	**13.** Kidney Disease	_____	☐	☐
4. Birth Defects	_____	☐	☐	**14.** Lung Cancer	_____	☐	☐
5. Breast Cancer	_____	☐	☐	**15.** Osteoporosis	_____	☐	☐
6. Colon Cancer	_____	☐	☐	**16.** Ovarian Cancer	_____	☐	☐
7. Diabetes	_____	☐	☐	**17.** Rheumatoid Arthritis/ Lupus	_____	☐	☐
8. Deep Vein Thrombosis	_____	☐	☐	**18.** Stroke	_____	☐	☐
9. Endometrial Cancer	_____	☐	☐	**19.** Uterine Cancer	_____	☐	☐
10. Heart Disease	_____	☐	☐	**20.** Other _____			

Social History

1. Marital Status: (Circle One) Single Married Long Term Relationship Divorced Widowed

2. Preferred Pronouns: (Circle One) She/Her He/Him They/Them

3. Do You Smoke: ☐ NO ☐ YES _____packs/day ☐ Former Smoker _____ packs/day _____ years

4. Occupation: _____

5. Religion: _____

6. Stress Level: (circle one) ☐ Low ☐ Medium ☐ High

7. Diet: Regular Vegetarian Other:_____

8. Exercise: Type: _____ How Often:_____

9. Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

10. Do you have sex with: ☐ Men ☐ Women ☐ Both

11. Sexually Active? ☐ NO ☐ YES

12. Has there been a new sexual partner in the last year? ☐ NO ☐ YES

13. Is sexual intercourse painful? ☐ NO ☐ YES

14. Current Birth Control Method: _____

15. Do You Drink Alcohol: ☐ NO ☐ YES How Many Drinks/Week? _____

16. Caffeine Intake: (circle one) None Occasional Moderate Heavy

17. Do You Use Illicit Drugs: ☐ NO ☐ YES Type _____Last Used _____

18. Number of Hours of Sleep Each Night: _____hrs.

Past Obstetrical/Gynecological Surgeries

Check any that apply or ☐ NONE

SURGERY	DATE	SURGERY	DATE
☐ D&C	_____	☐ L Cyst(s) Removed Ovarian	_____
☐ Hysteroscopy	_____	☐ R Cyst(s) Removed Ovarian	_____
☐ Infertility Surgery	_____	☐ L Ovary Removed	_____
☐ Laparoscopy	_____	☐ R Ovary Removed	_____
☐ Tuboplasty	_____	☐ Cesarean Section	_____
☐ Tubal Ligation	_____	☐ Myomectomy	_____
☐ Hysterectomy-Abdomen	_____	☐ Vaginal or Bladder Repair	_____
☐ Ovarian Surgery	_____	☐ Other_____	

Past Surgical History (Not OB/GYN)/ Hospitalizations

Please List All Surgeries: **OR** ☐ **NONE**

SURGERIES/ HOSPITALIZATIONS	**DATE**
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History ☐ NONE

- ☐ AIDS
- ☐ Anemia/Blood Disorder
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis/Lupus
- ☐ Asthma
- ☐ Birth Defects or Inherited Disease:
  Specify _____
- ☐ Blood Transfusion
- ☐ Breast cancer
- ☐ Breast Problem: Specify _____
- ☐ Cancer: _____
- ☐ Chlamydia/Gonorrhea
- ☐ Depression
- ☐ Diabetes: _____
- ☐ Deep Vein Thrombosis
- ☐ Endometriosis
- ☐ Female/Sexual Problems
- ☐ Headache
- ☐ Migraine: ☐with aura ☐without aura
- ☐ Herpes (HSV)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infertility
- ☐ Kidney or Bladder Problems
- ☐ Liver Disease: Specify _____
- ☐ Ovarian Cancer
- ☐ Psychiatric Illness: Specify _____
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Sexual Abuse/Domestic Violence: ☐Past ☐Current
- ☐ Stomach, Bowel or Gall Bladder Problems:
  Specify _____
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Varicosities (Varicose Veins)
- ☐ Other: _____