

PATRICIA BEARNSON M.D.P.C.
NEW PATIENT
HEALTH HISTORY QUESTIONNAIRE

NAME _____ **AGE:** _____ **DATE:** _____

GYN HISTORY

Age at 1st menses _____

Number of pregnancies _____ Living children _____ Miscarriages/abortions _____

If you are pre- or Perimenopausal:

Onset of last menstrual period _____ Are cycles regular? _____ Cycle length _____

Heaviness of menses _____ Bleeding between periods? _____

Are periods painful? _____ PMS? _____ Contraception method _____

If you are menopausal/postmenopausal:

Age at menopause _____ Do you now use hormone replacement therapy (HRT)? _____

If yes, what kind, including dose: _____

Have you continuously used HRT since menopause? _____ How many total years? _____

If no, have you ever used HRT? _____ How long? _____

Menopausal symptoms? Hot flashes _____ Vaginal dryness _____ Insomnia _____

Mood changes _____ Other _____

Any abnormal bleeding? _____

For everyone:

Are you sexually active? _____ Any sexual concerns? (libido, etc.) _____

Do you have incontinence (lose urine involuntarily)? _____ Is it mild _____ moderate _____ severe _____

Any bothersome vaginal discharge? _____ Past sexually transmitted diseases? _____

HEALTH SCREENING

Last pap smear (date) _____ Past abnormal pap? _____ If yes, how was it treated? _____

Last mammogram (date) _____ Where? _____

Past abnormal mammogram? _____ Past breast biopsy? _____

Sigmoid/colonoscopy _____

Bone density measurement? _____ When? _____ Result _____

Cholesterol/lipid check? _____ When? _____ Result _____

Thyroid check? _____ When? _____ Result _____

HEALTH RISK FACTORS:

Do you smoke now? _____ Not now, but in the past? _____ How long? _____ How much? _____

Alcohol? _____ How much? _____ Any recreational drugs? _____

Regular exercise? _____ What/how much? _____

Do you: Always use seat belts _____ Sun screen _____ Take calcium _____

Eat 5 or more fruits/vegetables per day _____ Do breast self-exam _____

Any bone fractures after age 40? _____ Where? _____

REASON FOR CURRENT VISIT

MEDICAL PROBLEMS

- 1. _____ Current? _____ Past? _____
- 2. _____ Current? _____ Past? _____
- 3. _____ Current? _____ Past? _____
- 4. _____ Current? _____ Past? _____
- 5. _____ Current? _____ Past? _____
- 6. _____ Current? _____ Past? _____

SURGICAL HISTORY

Have you had a hysterectomy? _____ Were your ovaries removed? _____
Reason for hysterectomy _____ Your age at the time _____
Have you had incontinence surgery? _____ What type? _____
Other surgeries: _____

MEDICATIONS (include dosage):

SUPPLEMENTS (Vitamins, herbs, etc):

ALLERGIES TO MEDICATIONS:

Other allergies: _____

FAMILY HISTORY:

Hypertension _____ Heart attack _____ Stroke _____ High cholesterol _____
Cancer: Breast _____ Uterine/ovarian/cervical _____ Colon _____ Melanoma _____ Other _____
Diabetes _____ Thyroid problems _____ Osteoporosis _____ Alzheimer's _____
Other _____