Todays Date: Patient Account#:	New Mexico Gynecology Consultants 4901 Lang Ave., NE Ste 203 Tel: (505) 242-5353, FAX: (505) 242-9788 Albuquerque, New Mexico 87109	**New Patient Medical History Questionnaire**

Demographics

Last Name:	***First Name:***	***MI:***	***Date of Birth:***	***(Age)***
Address:			***Social Security No:***	
City:	***State:***	***ZIP:***	***Home Telephone:***	
Employer:	***Occupation:***		***Work Telephone:***	

Marital Status:
- ☐ Single ☐ Separated ☐ Widowed
- ☐ Married ☐ Divorced ☐ Common-law

Race:
- ☐ Native American ☐ Caucasian ☐ East Indian
- ☐ Asian ☐ African American
- ☐ Hispanic ☐ Other

Emergency Contact: ***Telephone:*** ***Relationship:***

Primary Care Physician:

Referring Physician:

Introduction

Reason for <u>new patient</u> visit or Chief Complaint:

Current Medical Condition

Instructions:
Mark all That Apply

General	☐ Weight loss ☐ Weight gain ☐ Night sweats ☐ Fever	
Eyes	☐ Double vision ☐ Blind spots ☐ Eye pain ☐ Tearing	
Ears/Nose Mouth/Throat	☐ Dentures ☐ Neck pain ☐ Neck mass ☐ Dental problems ☐ Neck tenderness ☐ Nose bleeding ☐ Dizziness ☐ Nasal obstruction ☐ Lightheadedness ☐ Neck stiffness ☐ Bleeding gums	
Cardiovascular	☐ Chest pain ☐ Fainting ☐ Extremity painful with movement ☐ Swelling ☐ Phlebitis ☐ Shortness of breath with exertion ☐ Varicosities ☐ Heart murmur ☐ Irregular heart beat ☐ High blood pressure	☐ Shortness of breath lying down
Respiratory	☐ Wheezing ☐ Coughing up blood ☐ Pain with deep breathing ☐ Tuberculosis ☐ Cough ☐ Respiratory infections	
Gastrointestinal	☐ Poor appetite ☐ Nausea ☐ Abnormal stools ☐ Diarrhea ☐ Constipation ☐ Abdominal pain ☐ Heartburn/Burping ☐ Indigestion ☐ Vomiting blood ☐ Yellow skin ☐ Hemorrhoids ☐ Getting up at night to urinate ☐ Gas/Flatulence ☐ Vomiting ☐ Difficulty swallowing ☐ Recent changes in bowel habits	
Genitourinary	☐ Urgency ☐ Frequency ☐ Urinary incontinence ☐ Urinary infections ☐ Blood in urine ☐ Vaginal discharge ☐ Stones ☐ Lack of urine ☐ Frequent urination ☐ Nephritis ☐ Painful urination ☐ Vaginal itching or irritation	
Musculoskeletal	☐ Joint pain ☐ Muscle cramps ☐ Muscular weakness ☐ Limitation of motion	
Skin	☐ Rash ☐ Itching ☐ Changes in hair growth or loss ☐ Pigmentation ☐ Nail changes	
Breast	☐ Breast tenderness ☐ Breast swelling ☐ Nipple discharge ☐ Breast lumps	
Neurologic	☐ Convulsions ☐ Tremor ☐ Problem with muscular coordination ☐ Poor coordination ☐ Paralysis ☐ Sensory or motor disturbances ☐ Difficulties with memory or speech	

Current Medical Condition (continued)

Instructions: **Mark all That Apply**

Psychiatric	☐ Anxiety	☐ Nervousness	☐ Previous psychiatric care
	☐ Depression	☐ Hallucinations	☐ Emotional problems
Endocrine	☐ Diabetes	☐ Thyroid replacement	
	☐ Increased water intake		☐ Intolerance to heat or cold
Hematologic and Lymphatic	☐ Bleeding tendency	☐ Anemia	☐ Rh incompatibility
	☐ Lymph node enlargement or tenderness		☐ Previous transfusions and reactions
Allergic and Immunologic	☐ Reactions to drugs	☐ Reaction to food	☐ Skin reaction when around animals
	☐ Reaction to pollen		☐ Reaction to insect bites

Social History

Do you smoke cigarettes?	☐ No	☐ Yes	If **YES**, how many cigarettes per day? ( )		
Do you drink alcohol?	☐ No	☐ Yes	If **YES**, how many drinks per week? ( )		
Do you use recreational drugs?	☐ No	☐ Yes	If **YES**, which ones?		
Have you ever received a blood transfusion?	☐ No	☐ Yes	Do you exercise?	☐ No	☐ Yes
Have you recently been out of the Country?	☐ No	☐ Yes	Are you under a lot of stress?	☐ No	☐ Yes
Place of Birth:			If you were not born in the USA, how long have you lived in the states?	( ) Years	

Family History (Mark all that apply)

Disease	Father	Mother	Maternal Grandparent		Paternal Grandparents		Brother / Sister		Children and Yourself	
			Mother	Father	Mother	Father			Children	**YOURSELF**
Current Age **(Age)** or Deceased (D)	( )	( )	( )	( )	( )	( )	( )	( )	( )	
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeds Easily	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease/Stones	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Inherited Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Medical and Surgical History

Medical History

Please list all significant prior medical illnesses and current medical problems for which you are under medical treatment

Surgical History

Please list all surgical procedures you have had and the year they were performed

Year	**Procedure**

Trauma and Major Illness History

Surgery which was recommended but not completed	Have you ever been advised to have surgery which was not done? If so, describe	
	Year	**Describe**
Broken Bones?		
Injuries?		
Trauma?		
Have you been hospitalized for an illness?	**Year**	**Describe**

Obstetrical History

Obstetrical History						
Please list all pregnancies including miscarriages and ectopic pregnancies						
Number of Pregnancies: ( )		Number of Deliveries ( )			Number of Miscarriages ( )	
Number of Pregnancy Terminations ( )						
Year	**Vaginal or C-Section**	**Weeks of Pregnancy**	**Sex**	**Weight**	**Complications**	

Medications and Allergies

Medications				
Please list all current medications (including herbal medications) you are currently taking				
Medication	**Dosage**	**Frequency**	**Indication for Use**	

Allergies to Medications
Please list all allergies to medications:

Gynecologic History

Age at first period? ( )	When was your last period?	How far apart are your cycles? ( ) Days
Age at last period? ( )	How many days do they last? ( )	

Mark any symptoms associated with your periods:

☐ Cramps ☐ Heavy flow/clots ☐ Headaches ☐ Breast tenderness ☐ Change in mood ☐ Pelvic pain

Mark your current forms of birth control:

☐ None ☐ Depo Provera injections ☐ IUD ☐ Diaphragm ☐ Spermicide ☐ Natural

☐ Norplant ☐ Birth control pills ☐ Tubal ligation ☐ Family planning ☐ Vasectomy ☐ Condoms

Have you ever had an abnormal Mammogram?	☐ No	☐ Yes	If **YES**, what was abnormality: If **YES**, what was the treatment:	Date of Last Mammo:
Have you ever had an abnormal PAP smear?	☐ No	☐ Yes	If **YES**, what was abnormality: If **YES**, what was the treatment:	Date of Last PAP:
Are you currently sexually active?	☐ No	☐ Yes	Do you examine your breasts every month?	☐ No ☐ Yes
Do you desire a pregnancy at this time?	☐ No	☐ Yes	Do you have bleeding after intercourse?	☐ No ☐ Yes
Do you have pain with intercourse?	☐ No	☐ Yes	Have you stopped having periods?	☐ No ☐ Yes
Do you use douches?	☐ No	☐ Yes	Number of sexual partners in the last 12 months:	
Sexual Preference (mark one):	☐ Heterosexual		☐ Lesbian ☐ Bisexual	
Have you ever had a sexually transmitted disease?	☐ No	☐ Yes	If **YES**, which one(s): ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ PID ☐ HIV ☐ Hepatitis B ☐ Genital warts (HPV) ☐ Syphilis	☐ Trichomnoniasis

Immunizations

Tetanus Booster: A tetanus shot is important to prevent a potentially fatal disease called tetanus, more commonly referred to as lockjaw. The American College of Obstetricians and Gynecologists (ACOG) recommend that you be vaccinated every ten years.

☐ I do not need this vaccination	☐ I have had this vaccination, Date:	☐ I believe that I need this vaccination

Hepatitis B vaccine: This is potentially fatal infection of the liver. It is preventable with a series of three vaccinations. The ACOG recommend this vaccine be given to women whose jobs expose them to blood and body fluids. Other candidates for this vaccine include intravenous drug users, patients who receive blood products, people who have household or sexual contact with hepatitis B virus carriers, prostitutes, and people with multiple sexual partners.

☐ I do not need this vaccination	☐ I have had this vaccination, Date:	☐ I believe that I need this vaccination

Influenza vaccine: The influenza virus causes a self-limited respiratory infection in most people. However, elderly or ill people can develop fatal complications from infection. The ACOG recommend this vaccine be administered annually prior to the flu season starting at 55 years of age. Other candidates for the vaccine include residents of chronic care facilities, patients with cardiac or metabolic diseases (ex, diabetes, kidney disease), patients whose immune systems are compromised, and pregnant women in the second and third trimester.

☐ I do not need this vaccination	☐ I have had this vaccination, Date:	☐ I believe that I need this vaccination

Pneumococcal vaccine: A bacterial infection that causes pneumonia and meningitis caused by a streptococcus can be prevented by vaccination. The ACOG recommend this vaccine be given once lifetime to residents of chronic care facilities, patients with cardiac or metabolic diseases (ex, diabetes, kidney disease), patients whose immune systems are compromised, patients with sickle cell disease, Hodgkin's disease, alcoholism, cirrhosis, or multiple myeloma.

☐ I do not need this vaccination	☐ I have had this vaccination, Date:	☐ I believe that I need this vaccination

Health Questionnaire

Partner Violence Questionnaire

Have you been hit, kicked, punched or otherwise hurt by someone within 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			

Depression Questionnaire

I am unable to do the things I used to do.	☐ No	☐ Yes	I feel hopeless about the future.	☐ No	☐ Yes
I can't make decisions.	☐ No	☐ Yes	I feel sluggish and/or restless.	☐ No	☐ Yes
I am gaining/losing weight.	☐ No	☐ Yes	I get tired for no reason.	☐ No	☐ Yes
I am sleeping too little (or too much).	☐ No	☐ Yes	I feel unhappy.	☐ No	☐ Yes
			I think about killing myself.	☐ No	☐ Yes

Genetic Screening Questionnaire (Answer if you are of child bearing age and interested in pregnancy)

Have you, your partner, or anyone in either of your families ever had any of the following disorders:

Down Syndrome	☐ No	☐ Yes	Any Chromosomal abnormality	☐ No	☐ Yes
Spina Bifida or anencephaly	☐ No	☐ Yes	Hemophilia	☐ No	☐ Yes
Muscular Dystrophy	☐ No	☐ Yes	Cystic fibrosis	☐ No	☐ Yes

If **YES** to any of the above, what is the relationship:

Do you, your partner, or families have a disorder not listed above?	☐ No	☐ Yes	In any previous marriages, have you or your partner had a stillborn child or three first trimester pregnancy losses?	☐ No	☐ Yes
Do you or your partner have a birth defect?	☐ No	☐ Yes	Are you and your partner blood relatives?	☐ No	☐ Yes
Are you or your partner African American?	☐ No	☐ Yes	Are you or your partner of Jewish or Cajun ancestry?	☐ No	☐ Yes
Are you or your partner Hispanic?	☐ No	☐ Yes	Are you or your partner Italian, Greek, or Mediterranean ancestry?	☐ No	☐ Yes
Are you or your partner of Philippine ancestry?	☐ No	☐ Yes	Are you or your partner of Chinese, or South Asian ancestry?	☐ No	☐ Yes

Urinary Incontinence Questionnaire (Answer if you are having difficulty with urinary incontinence)

Have you had treatment for urinary disease, such as stones, kidney disease, infections, tumors, or injuries?	☐ No	☐ Yes	When you lose your urine accidentally, are you ever unaware that it is passing?	☐ No	☐ Yes
Have you had repeated bouts of pyelitis?	☐ No	☐ Yes	Do you have a severe sense of urgency before you lose urine?	☐ No	☐ Yes
Is your urine ever bloody?	☐ No	☐ Yes	Do you lose urine as a constant drip from the vagina?	☐ No	☐ Yes
Did you have difficulty holding urine as a child?	☐ No	☐ Yes	Is it usually painful or difficult to pass your urine?	☐ No	☐ Yes
What is the usual amount of urine you void?	☐ Large	☐ Average	☐ Small	☐ Very small	
Did you wet the bed as a child?	☐ No	☐ Yes	Do you wet the bed now?	☐ No	☐ Yes
Does the sound or feel of running water cause you to lose urine?	☐ No	☐ Yes	Is your urine loss a continual drip, so that you are constantly wet?	☐ No	☐ Yes
Are you ever unaware that you are losing, or are about to lose control of your urine?	☐ No	☐ Yes	Do you find it necessary to have your urine removed by means of a catheter because you are unable to pass it?	☐ No	☐ Yes
Is your clothing slightly damp, wet, or soaking wet, or do you leave puddles on the floor?	☐ No	☐ Yes	Do you find it necessary to wear protection because you get wet?	☐ No	☐ Yes
Do you lose urine by spurts, during coughing, sneezing, laughing, or lifting?	☐ No	☐ Yes	Do you have difficulty holding urine if you suddenly stand erect from a sitting or lying position?	☐ No	☐ Yes
Do you lose urine when you are lying down?	☐ No	☐ Yes	Do you lose urine when you are sitting or standing erect?	☐ No	☐ Yes
When urinating, are you unable to stop the flow?	☐ No	☐ Yes	Did your urine difficulty start after delivery of an infant?	☐ No	☐ Yes
Did your urine difficulty start after an operation?	☐ No	☐ Yes	Have you had an operation on your spine, brain, or bladder?	☐ No	☐ Yes

Health Questionnaire (continued)

Pelvic Relaxation Questionnaire

Do you need to put a finger in your vagina to allow a bowel movement?	☐ No	☐ Yes	Do you have a feeling of pelvic heaviness, especially with prolonged standing?	☐ No	☐ Yes
Do you have a sensation that organs are falling out from your vagina?	☐ No	☐ Yes	Do you feel that your rectum is not empty after a bowel movement?	☐ No	☐ Yes

Osteoporosis Questionnaire

Do you have chronic back or joint pain?	☐ No	☐ Yes	Were you less than age 45 when your normal menstrual cycle stopped?	☐ No	☐ Yes
Do you regularly take the following medications: Thyroid hormone (Synthroid, Prednisone)?	☐ No	☐ Yes	Since the age of 45, have you broken a hip, wrist, or rib?	☐ No	☐ Yes
Are you Caucasian or Asian?	☐ No	☐ Yes	Has it been at least five years since your last menstrual cycle?	☐ No	☐ Yes
Do you currently smoke cigarettes?	☐ No	☐ Yes	Are you taking steroid-based drugs for asthma, arthritis or cancer?	☐ No	☐ Yes
Have you experienced a height loss of at least 1.5 inches in your lifetime or has a doctor told you that you have a significantly curved upper back?	☐ No	☐ Yes	Are you Milk intolerant or have a low calcium intake?	☐ No	☐ Yes

Alcohol Questionnaire

Have you ever felt bad or guilty about your drinking?	☐ No	☐ Yes	Have people annoyed you by criticizing your drinking?	☐ No	☐ Yes
Have you ever felt you ought to cut down on your drinking?	☐ No	☐ Yes	Have you ever had a drink the first thing in the morning to steady your nerves or get rid of a hangover?	☐ No	☐ Yes

Conclusion

Please describe any other issues you wish to discuss with the medical provider:

Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices for New Mexico Gynecology Consultants and Southwest Clinical Research in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature: _____ Date: _____

Clinical Research Participation

New Mexico Gynecology Consultants and Southwest Clinical Research frequently has opportunities for clinical patients to participate in studies. One of the recruitment methods available to us is from a review of prior and current clinical research participant records. You may elect to be included or excluded in these record reviews. Please indicate your preference below:

☐ INCLUDE me in any reviews for clinical research.

☐ EXCLUDE me in any reviews for clinical research.

Signature: _____ Date: _____