Visalia Ob/Gyn Medical Associates, Inc
New Patient Health Questionnaire

Name _____

Occupation _____

Primary Care Physician _____

We encourage all patients to have a family or internal medicine doctor.

Marital Status: Single Married Widowed Divorced Separated Other

Past and Current Medical History - Mark all that apply

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol/Lipid abnormalities
- ❑ Asthma
- ❑ Thyroid Problems
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Genital Herpes
- ❑ Fibroids
- ❑ Uterine Abnormality
- ❑ Polycystic Ovaries
- ❑ Blood Clots
- ❑ Gastric Reflux
- ❑ Blood transfusion
- ❑ Treatment for an Abnormal Pap Smear
- ❑ Treatment for Infertility
- ❑ Sexually Transmitted Diseases
- ❑ Heart Problems - Mitral Valve Prolapse
- ❑ Lung Diseases
- ❑ TB
- ❑ Valley Fever
- ❑ Stomach or Intestinal Problems
- ❑ Freezing or LEEP of the Cervix
- ❑ Osteoporosis
- ❑ Anxiety/Depression/Psychiatric Illness
- ❑ Seizures
- ❑ Anemia
- ❑ HIV/AIDS
- ❑ Environmental Allergies
- ❑ Arthritis
- ❑ Skin Diseases
- ❑ Collagen Vascular Diseases
- ❑ Chicken pox/Shingles
- ❑ Hypertension
- ❑ Autoimmune Disorders
- ❑ Gastrointestinal Disorders
- ❑ Neurologic Disorders
- ❑ Bleeding Disorders
- ❑ Cancer _____
- ❑ Other_____
  _____

In the past year, has a medical problem led to you being seen in the ER? ___ No___ Yes_____

In the past year, has a medical problem led to you being hospitalized? ___ No___ Yes_____

Past Operations - Mark all that apply

- ❑ Appendix Removal
- ❑ Tonsil Removal
- ❑ Gallbladder Removal
- ❑ Cesarean Section
- ❑ Ectopic Pregnancy
- ❑ Cosmetic surgery
- ❑ Endometrial Ablation
- ❑ Bladder Surgery
- ❑ Tubal Ligation or Excision (BTL)
- ❑ Laparoscopy
- ❑ Hysterectomy
- ❑ Biopsies
- ❑ Cryotherapy of cervix
- ❑ Bone or Joint Surgery
- ❑ Spine/Brain Surgery
- ❑ Gastric Bypass
- ❑ LEEP
- ❑ Breast Surgery
- ❑ Heart Surgery or Catheterization
- ❑ Abdominoplasty
- ❑ Anesthesia Problems
- ❑ Thyroid Surgery
- ❑ Removal of Ovaries or Ovarian Cyst(s)
- ❑ Other_____

Medications/Habits

Allergy to (please circle): Latex Surgical tape

Medication allergies: _____

Current prescription medications: _____

Current over the counter medications: _____

Have you ever smoked/vaped? Yes No Currently _____ packs per day

Do you drink alcohol? Yes No How many drinks per week?_____

In the last 2 years have you used?

Marijuana	Yes	No	Ecstasy	Yes	No	Methamphetamines	Yes	No
Cocaine/crack	Yes	No	Heroin	Yes	No	Other drugs	Yes	No
			Amphetamines	Yes	No	_____		

Family History

Does anyone in your family (parents, grandparents, siblings, children) have? Who has it? Mark all that apply

- ❑ Diabetes_____
- ❑ Elevated Cholesterol_____
- ❑ High blood pressure_____
- ❑ Thyroid disease_____
- ❑ Cardiac disease _____
- ❑ Neurological disease _____
- ❑ Asthma _____
- ❑ Cancer _____
- ❑ Kidney disease _____
- ❑ Osteoporosis_____
- ❑ Diseases of the blood_____
- ❑ Psychiatric disorder_____

Obstetric History (Skip if no history of pregnancy)

_____ Total pregnancies
_____ Full term births (within 3 weeks of due date)
_____ Preterm births (20 weeks to 36 weeks)
_____ Miscarriages (losses before 20 weeks)
_____ Pregnancy terminations
_____ Ectopic pregnancies
_____ Multiple births (twins, triplets)
_____ Living children

Other Information

Are you having periods? Yes___ No___ If yes, First day of last menstrual period ____/____/____

When was your last pap smear? ____/____/____ Was it normal? Yes___ No___

Have you ever been treated for an abnormal pap smear? Yes___ No___

Have you ever had a mammogram? Yes___ No___ If yes, date of most recent ____/____/____

Are you currently using anything for birth control? Yes___ No___

If yes, mark all that apply:

- ❑ Tubal Occlusion/Removal
- ❑ Intrauterine Device (IUD)
- ❑ Birth Control Pill – Name:_____
- ❑ NuvaRing
- ❑ Nexplanon
- ❑ Vasectomy
- ❑ Condoms
- ❑ Natural Family Planning

When was your last

____/____/____Colonoscopy/Flexible Sigmoidoscopy?

____/____/____Bone density test?

____/____/____Screening blood tests?