

# *Georgetown Ob-Gyn*

Dr. Vincent Sherman

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## New Gynecology Patient Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Age: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

1. When was the first day of your last normal menstrual period? \_\_\_\_\_  
 a. How often do you have a period (ie. every 4 weeks)? \_\_\_\_\_  
 b. Are they  light  moderate or  heavy

4. Are you allergic to any medications?  Yes  No Are you allergic to latex?  Yes  No

If yes, explain which medication(s) and what type of reaction: \_\_\_\_\_

5. List of your medications, including non-prescription, herbal remedies, and vitamins with doses.


6. Do you smoke?  Yes  No. If yes, how many cigarettes per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No. If yes, what type and how much per week? \_\_\_\_\_

Do you use illegal drugs?  Yes  No. If yes, what time and how often? \_\_\_\_\_

What type of exercise do you get? \_\_\_\_\_ How often? \_\_\_\_\_

7. Do you have any medical problems or any history of medical problems (ie. High blood pressure, cancer, thyroid disease)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Check any of the problems that you or an immediate family member has?

	Self	Family member, who?
Heart disease or high blood pressure		
Diabetes		
Breast Cancer		
Ovarian or Uterine Cancer		
Other Cancer		
Blood Clots		

	Self	Family member, who?
Osteoporosis		
Asthma		
Seizures		

8. Have you ever had any of the following?

	Yes or No	When?
Abnormal Pap smear		
Sexually Transmitted disease		

9. List all surgeries you have had.

Surgery	When?	Why?

10. Have you been hospitalized for any reason other than childbirth and above listed surgeries? If yes, explain when and why. \_\_\_\_\_

\_\_\_\_\_

11. Please fill out below table regarding any pregnancies.

Pregnancy	Date	Outcome (miscarriage, ectopic, vaginal delivery or C-section)
1 <sup>st</sup>		
2 <sup>nd</sup>		
3 <sup>rd</sup>		
4 <sup>th</sup>		
5 <sup>th</sup>		

12. When was your last?

Pap \_\_\_\_\_ Result \_\_\_\_\_

Mammogram \_\_\_\_\_ Result \_\_\_\_\_

Colonoscopy \_\_\_\_\_ Result \_\_\_\_\_

Flu shot \_\_\_\_\_

Tetanus shot \_\_\_\_\_