Women's Health Alliance of New Jersey

142 Highway 35, Suite 105 Eatontown, New Jersey Tel:732-935-0700 Fax:732-935-0731

GYNECOLOGIC HISTORY

Please complete the following questionnaire

Name_____ Date_____

First day of last period_____ Number of days between periods _____

Current method of birth control _____ **past** methods of birth control_____

Age at first period _____

How many days does your period usually last?_____

Do you have bleeding or spotting between periods?_____

Date of last Pap smear? _____Normal? ☐ YES ☐ NO:_____(result/diagnosis)

History of Abnormal Pap? ☐ YES ☐ NO:_____(RESULT)

Date of last Mammogram? _____Normal? ☐ YES ☐ NO:_____(result/diagnosis)

Have you had a DEXA scan(bone density test)? ☐ YES ☐ NO

Have you had a colonoscopy? ☐ YES ☐ NO If so, when? _____

Please check if you have had or currently have any of the following infections?

☐ Yeast ☐ Trichomonas ☐ Chlamydia ☐ Gonorrhea

☐ Herpes ☐ HPV ☐ HIV ☐ MRSA ☐ Other:_____

SEXUAL HISTORY

Are you sexually active? ☐ NO ☐ YES

If yes, is sex: ☐ Satisfactory ☐ Uncomfortable ☐ Wish to Discuss

---

OBSTETRICAL HISTORY

Number of pregnancies:_____Miscarriages:_____Abortions:_____Live Births:____

Did you have an episiotomy?_____

Did you have Gestational Diabetes?_____

Did you have Pre-eclampsia/Toxemia during pregnancy?_____

Weight of Baby	Type of Delivery

SOCIAL HISTORY *please complete this section entirely and honestly*

Tobacco: □ No □ Yes Current Use: □ No □ Yes For how long?_____

How frequently/ How many cigarettes per day? _____

Alcohol: □ No □ Yes How many ounces per week? _____

Caffeinated beverages: □ No □ Yes Type, frequency and amount:_____

Street Drugs: □ No □ Yes Type, frequency and amount:_____

Have you ever sought treatment for addiction(street drugs or prescriptions): □ No □ Yes

If yes, for what and when? _____

Have you ever had a Pain Management Contract with any healthcare providers?

□ No □ Yes

Do you do any type of exercise? □ No □ Yes If yes, what type(s): _____

SURGERIES AND HOSPITALATIONS

List any surgeries and serious illnesses, which required hospitalization (excluding pregnancy)

Surgery/Hospitalizations Date

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS

List all medications you currently take, with dosage and frequency, including over-the-counter-drug.

Medication Dosage How Often Taken?

_____

_____

_____

_____

_____

Herbal Supplements/Vitamins

List all supplements you are currently taking.

Supplement Name Dosage How Often Taken?

DRUG ALLERGIES INCLUDING LATEX, IV DYE, IODINE OR ADHESIVES

List all drugs you are allergic to and the allergic reaction to each drug

Medication/Product Reaction

PAST/PRESENT MEDICAL HISTORY: PATIENT ONLY

Please note if you been diagnosed with any of the following conditions. In the "Please Explain" column, please indicate when you had this condition

Condition/Disorder/Disease	YES	NO	Please Explain
Allergies, Immune & Infectious Problems (hay fever, seasonal allergies, HIV, Lupus, etc...)	◯	◯	
Blood & Lymph Node (Anemia, Blood Clot/Transfusion, bleeding disorder)	◯	◯	

Bones/Joints and Muscles (Arthritis, etc...)	◯	◯	
Cancer (What type of cancer)	◯	◯	Please explain and indicate treatment (chemo, radiation, other):
Gynecological Cancer (ovarian, uterine, endometrial)	◯	◯	
Cardiovascular (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery, heart disease, high cholesterol)	◯	◯	
Constitutional (chronic cough, fever, weight loss, poor appetite)	◯	◯	
Ear/Nose/Throat (hearing loss, sinus, sour throat, frequent bloody noses)	◯	◯	
Endocrine (diabetes, thyroid or pituitary problems, etc...)	◯	◯	
Eyes (eye disease, glaucoma, cataract, lazy eye, retina problems)	◯	◯	
Gastro-Intestinal (heartburn, acid reflux, diarrhea, vomiting, ulcer, IBS, etc...)	◯	◯	
Genito - Urinary (urinary problems, blood in urine, etc...)	◯	◯	
Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc...)	◯	◯	
Lungs and Respiratory (asthma, tuberculosis, shortness of breath, wheezing, coughing or problems with anesthesia	◯	◯	
Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joints, arthritis, etc...)	◯	◯	
Neurologic (numbness, weakness, paralysis, headaches, spasm, seizers, Fibromyalgia, MS, etc...)	◯	◯	
Psychiatric (depression, anxiety, etc...)	◯	◯	
Skin (skin rashes, excessive dryness, used Acutance, skin	◯	◯	

cancer/disease,etc...)			
Infectious Disease (Hepatitis B, HIV or AIDS, Tuberculosis, etc...)	◯	◯	
Anything Else We Should Know About:			

FAMILY MEDICAL HISTORY

(Please specify Maternal or Fraternal)

Please note **any blood - relatives** that have had any of the following conditions

Condition/Disorder/Disease:	Yes	No	Please Explain
Breast Disease	◯	◯	
Cardiovascular (heart problems, high blood pressure, stroke, pacemaker, heart surgery, heart disease)	◯	◯	
Diabetes	◯	◯	
Gynecological Cancer (ovarian, uterine, endometrial)	◯	◯	
Hepatitis B or C, HIV or AIDS, Tuberculosis etc...	◯	◯	
Other:			
Other:			

I have **completed all parts of this form** and understand that it is my responsibility to provide an accurate medical history and disclose all information relevant to my health; and that accuracy of such information is crucial to my care at Women's Health Alliance of New Jersey

Print Name

If other than patient, please indicate relationship and provide Power-of-Attorney at appointment

Sign Here→ _____ / / /

Signature of Patient or Authorized Representative

Date(month/day/year)

Checklist:

☐ I have filled out all parts of this form.

Please Bring To Your Appointment:

☐ Drivers License and Insurance Card(s)

☐ Patient Demographic Form

☐ **Completed** Medical History Questionnaire, as well as:

- ☐ Any list of any questions or concerns that you would like to discuss with the provider
- ☐ Any list of *all* of the medications, vitamins, and supplements you take
- ☐ A current list of *all* allergies you suffer from (environmental and pharmaceutical) and associated reactions

Co-Payment is due at time of service

This is the last page of your New Patient Packet.
Thank You for completing, we look forward to serving your health care needs.
Please bring the **entire** packet to your appointment
If you have any questions call us at (732)935-0700