ruch CLINIC

Excellence in Women's Health is our Legacy

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Pharmacy Name and Location: _____

New Patient History Questionnaire

Reason for today's visit: Please include any specific symptoms or concerns _____
_____
_____

MEDICATIONS: Please include prescribed, over the counter, vitamins, supplements, etc. (Please include dosage)

1) _____ 3)_____ 5)_____
2) _____ 4)_____ 6)_____

ALLERGIES: Yes No **If yes,** please list and include reaction: _____

GYNECOLOGICAL HISTORY:

Do you still have cycles? Yes No

If yes, First day of last menstrual cycle:_____ Age at first menstrual period:_____

How frequent do your periods come? Every _____ days OR _____ month(s) How long do your periods last? _____

Are your period's heavy? Yes No **If yes**, how many pads/tampons do you use per day? _____

Do you experience *significant cramping* with your period? Yes No Do you spot between periods? Yes No

If no, and menopausal: Age of onset: _____ Any issues with hot flashes? _____

and Hysterectomy: Type: _____ Year: _____ Reason for surgery:_____

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No

If yes, your current partner(s) is/are? Male Female Have you had any new sexual partners in the past year? Yes No

What type of contraception do you use currently (if applicable): Contraceptive Pills Condoms IUD Patch Ring
DepoProvera Rhythm Method Withdrawal Vasectomy Tubal Ligation None Abstinence Nexplanon

Have you ever had an abnormal Pap smear? Yes No Date of last Pap smear? _____

If yes, what therapy was required **(Please include date)**? Cryotherapy (freezing) Laser Cone Biopsy Colposcopy LEEP

Have you ever had any infections of the reproductive tract or any sexually transmitted diseases (STDs)? Yes No

If yes, which one(s): Gonorrhea Chlamydia Pelvic Inflammatory Disease HIV Herpes Syphilis
Hepatitis Human Papilloma Virus (HPV) Trichomonas Other: _____

Do you have any current issues with incontinence or loss of urine? Yes No **If yes**, please describe _____

Do you examine your breasts regularly? Yes No Any current breast problems or changes? _____

Have you ever had a breast biopsy? Yes No **If yes**, Date:_____ Results:_____

OBSTETRICAL HISTORY:

Have you ever been pregnant? Yes No **If yes**, please indicate the total number of pregnancies:

Term Delivery #_____ C-section #_____ Living Children #____ Ectopic #_____

Preterm Delivery #_____ Vaginal #_____ Miscarriage #_____ Termination # _____

Please list any pregnancy complications: _____

Have you had infertility treatments? Yes No **If yes**, describe _____

MEDICAL HISTORY:

Do you have any current or chronic medical conditions? Yes No

If yes, please list: _____
_____

SURGICAL HISTORY:

Have you had any surgeries or procedures? Yes No

If yes, please include any requiring anesthesia, breast biopsies, and D&C's **(Please include date)** _____

_____

_____

TESTS/IMMUNIZATIONS:

Tetanus Date: _____	Shingles Date: _____	Rubella: _____ Date: _____
Hepatitis B Date: _____	Gardasil Date: _____	Other: _____ Date: _____
Hepatitis A Date: _____	Flu Date: _____	Other: _____ Date: _____

Colonoscopy Yes No Date _____ Mammogram Yes No Date _____

Cardiac Screen Yes No Date _____ Bone Density Yes No Date _____

Other _____

SOCIAL HISTORY:

What is your marital status? _____

What is your occupation? _____ What is your partner's occupation, if applicable? _____

Do you use TOBACCO? Never Current Past **If yes**, Cigarettes a day _____ for # of years_____

Do you drink ALCOHOL? Yes No **If yes**, Drinks per week# _____ OR Drinks per month_____

Do you use recreational drugs? Yes No **If yes**, please describe: _____

Do you exercise? Yes No **If yes,** how many days a week? _____

FAMILY HISTORY:

Please indicate if any members of your family have/had the following: **(Please list their relation to you)**

High Blood Pressure_____ Osteoporosis_____

Heart Attack_____ Sickle Cell_____

Heart Disease_____ Breast Cancer_____

Stroke _____ Colon Cancer_____

Blood Clotting Disorder_____ Ovarian Cancer_____

Thyroid Disorder_____ Uterine Cancer_____

Diabetes_____ Other: _____

Adopted or Family History Unknown? Yes No

REVIEW OF SYSTEMS: Please check any ***current, significant*** symptoms

Constitutional
____Fatigue
____Weight Change
____Fever/ Chills

ENT
____Nose Bleeds
____ Sore Throat

Respiratory
____Wheezing
____Coughing
____Shortness of Breath

Cardiovascular
____Chest Pain
____Palpitations

Gastrointestinal
____Abdominal Pain
____Blood/ Change in Stool
____Nausea/Vomiting

Genitourinary
____Painful Urination
____Frequency of Urination
____Leakage of Urine
____ Blood in Urine

Endocrine
____ Excessive Thirst
____ Cold or Heat Intolerance
____ Hair Loss
____Appetite Change

Musculoskeletal/Skin
____Joint/Muscle Pain
____Swelling in legs
____Easy bruising or bleeding
____Rash/Itching
____Change in Mole/Lesion

Mood
____Anxiety
____Depression

Neurologic
____ Headaches
____Weakness

Please list your Primary Care Doctor and all health practitioners/specialists that you are currently seeing:

Physician Name Phone/Location

1) _____
2) _____
3) _____
4) _____