Gigi Kroll, MD ✦ Zhanna M. Pinkus, MD

180 Newport Center Drive, Suite 265, Newport Beach, CA 92660
T 949 706 0181 F 949 706 7187
www.newportcenterwomenshealth.com

PATIENT QUESTIONNAIRE

Please bring this completed form to your scheduled appointment (DO NOT MAIL).

Name: _____ Age: _____ Date/Time: _____

What brings you to the office today: _____

Who referred you to our office: _____

Do you have any questions, problems, or concerns that you would like to discuss with us today? _____

_____

_____

_____

MENSTRUAL/GYNECOLOGICAL HISTORY

Date of your last period: _____

Has there been a change in your periods? Yes ☐ No ☐ *If yes, please specify*: _____

Do you have hot flashes, night sweats, or trouble sleeping? Yes ☐ No ☐ *If yes, please specify*: _____

_____

Are you taking any hormones? Yes ☐ No ☐ *If yes, please specify*: _____

_____

Are you taking any vitamin, calcium, herbal or other supplements? Yes ☐ No ☐ *If yes, please specify* : _____

_____

Age period started: _____ # of days your period last: _____ Days between periods: _____

Cramps? Yes ☐ No ☐ PMS? Yes ☐ No ☐

OBSTETRICAL HISTORY

Number of pregnancies _____ Vaginal deliveries _____ C-Section _____ Miscarriages _____ Abortions _____

SEXUALITY HISTORY

Do you use a method of contraception? Yes ☐ No ☐

If yes, what type? ☐ pills ☐ IUD ☐ diaphragm ☐ spermicide ☐ natural/rhythm
☐ sponge ☐ condoms ☐ other _____

Do you want any information about birth control/safer sex? Yes ☐ No ☐

Have you ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Venereal Warts ☐ Herpes

Do you have pain with sexual intercourse? Yes ☐ No ☐

Any other problems with sex? _____

URINARY HISTORY

Do you lose urine involuntarily? Yes ☐ No ☐

Do you frequently have a strong, sudden urge to urinate? Yes ☐ No ☐

Do you get up 2 or more times during the night to go the bathroom? Yes ☐ No ☐

Do you sometimes not make it to the bathroom in time? Yes ☐ No ☐

Do you to the bathroom more than 8 times during a 24-hour period? Yes ☐ No ☐

BREAST HISTORY

Do you have fibrocystic condition Yes ☐ No ☐

Have you ever had a breast lump or cyst Yes ☐ No ☐ *Biopsy results:* _____

Do you experience breast pain? Yes ☐ No ☐

When was your last mammogram? _____ *Results:* _____

Where was your last mammogram performed? _____

SCREENING SECTION:

Date of your last Pap test: _____ *Date of your last stool test*: _____

Have you ever had an abnormal Pap? Yes ☐ No ☐ *If yes, please specify*: _____

Have you had a colon examination ("**sigmoidoscopy**") within three to five years after age 50 (more often for high-risk people)?

Yes ☐ No ☐ *If yes, when?* _____

Have you ever had a Bone Density Exam? Yes ☐ No ☐ *If yes, when?* _____

MEDICAL HISTORY

Have you had any illnesses? Yes ☐ No ☐ *If yes, please specify:* _____

Please list all doctors who you see now: **Primary Care:**_____**Specialist:**_____

Please list all medications including herbal and OTC _____

_____

Drug allergies? Yes ☐ No ☐ *If yes, please specify*: _____

Food or environmental allergies? Yes ☐ No ☐ *Results*: _____

Has your cholesterol been tested? Yes ☐ No ☐ Don't Know ☐

Are your blood tests normal? Yes ☐ No ☐ Have not had ☐

Do you get regular dental and eye exams? Yes ☐ No ☐ *Any Problems*? _____

Do you have problems hearing? Yes ☐ No ☐

Vaccine History Date: _____Tetanus _____Hep. B_____Hep. A_____Flu _____HPV (Gardasil)

SURGICAL HISTORY

Please list all surgeries - gynecological, plastic, or other. Please include dates/year). _____

_____

_____

FAMILY MEDICAL HISTORY

Have you or anyone in your family (parents, brothers, sisters, children, grandparents, aunts, uncles, cousins) ever been diagnosed with:

	SELF YES	*If yes, when diagnosed*	FAMILY YES	*If yes, Who?*
Heart Disease	☐		☐	
High Blood Pressure	☐		☐	
Stroke	☐		☐	
Diabetes	☐		☐	
Lung Problems	☐		☐	
Thyroid Problems	☐		☐	
Blood Disorders	☐		☐	
Early Menopause	☐		☐	
DES Exposure	☐		☐	
Tubal Infection	☐		☐	
Infertility	☐		☐	
Varicose Veins	☐		☐	
Arthritis	☐		☐	
Osteoporosis	☐		☐	
Breast Cancer	☐		☐	
Ovarian Cancer	☐		☐	
Colon Cancer	☐		☐	
Uterine Cancer	☐		☐	
Lung Cancer	☐		☐	
Melanoma/Skin Cancer	☐		☐	
More than 1 kind of cancer	☐		☐	
Diagnosed in the same person			☐	
Other types of cancer	☐		☐	
Birth Defects	☐		☐	
Mental Retardation	☐		☐	
Multiple miscarriages	☐		☐	
Childhood Tumors	☐		☐	

SOCIAL HISTORY

What is your occupation? _____ Have you recently changed jobs? Yes ☐ No ☐

Do you have any problems at home? Yes ☐ No ☐ *If yes, please specify*: _____

Has there been any change in your relationship with your husband, partner, or boyfriend? Yes ☐ No ☐

If yes, please specify: _____

How are you relationships with others? _____

Do you suffer from anxiety or depression? _____

Do you smoke cigarettes? Yes ☐ No ☐ FORMER ☐ *How much/how long?* _____

Do you use street drugs? Yes ☐ No ☐ *If yes, please specify*: _____

Do you drink alcohol on a regular basis? Yes ☐ No ☐ *If yes, please specify*: _____