DINESEN & ASSOCIATES
OBGYN & INFERTILITY

NEW PATIENT QUESTIONNAIRE

Welcome! We are happy and honored that you have decided to join our practice. We aspire to provide the best in women's healthcare. In order for us to accomplish great healthcare, we need to know about you, your health, your history, and your life.

Please be as complete as possible.

NAME:_____ AGE:_____ D.O.B. ___/___/___
EMAIL ADDRESS: _____
HOME PHONE: _____
CELL PHONE: _____
PRIMARY PHYSICIAN: _____
PHARMACY NAME: _____ PHONE NUMBER: _____
EMERGENCY CONTACT: _____ PHONE: _____
HOW WERE YOU REFERRED TO OUR PRACTICE? _____
REASON FOR VISIT: _____

DRUG ALLERGIES? _____
ALLERGY TO LATEX? YES NO
CONTRACEPTION TYPE: _____

MEDICATION NAME	**DOSE**	**HOW MANY TIMES/DAY?**	**PRESCRIBING PHYSICIAN**

FIRST DAY OF LAST PERIOD? _____/_____/_____ CYCLE LENGTH: _____DAYS
AGE OF FIRST PERIOD: _____ AGE OF MENOPAUSE: _____
DO YOU CURRENTLY SMOKE? YES NO PAST SMOKER? YES NO
HOW MANY PACKS/DAY? _____ HOW MANY YEARS? _____
DO YOU DRINK ALCOHOL? YES NO HOW MANY DRINKS WEEKLY? ___
HISTORY OF DRUG USE? YES NO DETAILS: _____
DO YOU EXERCISE? YES NO DETAILS: _____
DO YOU FEEL SAFE AT HOME? _____
DO YOU FEEL SAFE AT WORK? _____
HAVE YOU EVER BEEN ABUSED SEXUALLY, PHYSICALLY, OR EMOTIONALLY?
_____

PAST MEDICAL HISTORY

MEDICAL CONDITION	YEAR STARTED?	CURRENT PROBLEM? YES/NO	TREATING PHYSICIAN

PAST SURGICAL HISTORY

SURGERY	YEAR	PHYSICIAN

PAST OBSTETRICAL HISTORY

Please include all miscarriages, abortions, and ectopic pregnancies

DATE	WEEKS	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	HOSPITAL

FAMILY HISTORY

RELATION	CONDITION	AGE OF ONSET	ALIVE/DECEASED

REVIEW OF SYSTEMS (Check all that apply to you currently)

CONSTITUTIONAL		**GU**		**PSYCHIATRIC**	
CHILLS	☐	PAINFUL URINATION	☐	ANXIETY	☐
FATIGUE	☐	BLOOD IN URINE	☐	DEPRESSION	☐
FEVER	☐	URINARY FREQUENCY	☐	INSOMNIA	☐
NIGHT SWEATS	☐	URINARY INCONTINENCE	☐	**METABOLIC**	
WEIGHT GAIN	☐	**REPRODUCTIVE**		COLD INTOLERANCE	☐
WEIGHT LOSS	☐	PAINFUL PERIODS	☐	HEAT INTOLERANCE	☐
HEENT		PAIN WITH INTERCOURSE	☐	**MUSCULOSKELETAL**	
EYE PAIN	☐	IRREGULAR PERIODS	☐	BACK PAIN	☐
HEARING LOSS	☐	HEAVY PERIODS	☐	JOINT PAIN	☐
VISUAL CHANGES	☐	BREAST LUMP	☐	JOINT SWELLING	☐
RESPIRATORY		**SKIN**		MUSCLE WEAKNESS	☐
COUGH	☐	HAIR LOSS	☐	**HEMATOLOGIC**	
SHORTNESS BREATH	☐	RASH	☐	EASY BLEEDING	☐
CARDIOVASCULAR		ITCHING	☐	EASY BRUISING	☐
CHEST PAIN	☐	**NEUROLOGICAL**		**IMMUNE**	
PALPITATION	☐	DIZZINESS	☐	ENVIRONMENTAL ALLERGIES	☐
GI		HEADACHE	☐	FOOD ALLERGIES	☐
ABDOMINAL PAIN	☐	MEMORY LOSS	☐	SEASONAL ALLERGIES	☐
DIARRHEA	☐				
NAUSEA	☐				
VOMITING	☐				

☐ **Check here if all above are negative**

Is there anything else about your history that you think is important for us to know?

_____

_____

_____

_____

SIGNATURE

1/1/16