VIVI WOMEN'S HEALTH
GYNECOLOGY & OBSTETRICS

New Patient Questionnaire

Name: _____ Date of birth: _____
Pharmacy: _____ Referred by: _____
Occupation:_____ Primary care physician: _____
Reason for visit: _____

Gynecologic history:

First day of last menstrual period: _____
Age of cycle onset: ____ Cycle every: ____ days Length: ____ days Menopause in _____
Cycle history: ____ Regular ____ Irregular ____ Heavy ____ Painful

Sexual orientation: ____ Heterosexual ____ Homosexual ____ Bisexual Marital Status: _____
Currently sexually active? __Y __N History of sexual activity? __Y __N
Birth control method: _____ Pleased with method? Y/N
Past methods used: _____ History of STDs? (list if yes): _____

Date of last: Pap smear_____ Mammogram_____ Colonoscopy _____ Bone density _____
History of abnormal results? (Include treatments)_____

Personal history (circle): Infertility/ endometriosis/ fibroids/ urinary incontinence/ UTIs/ Pelvic pain/PID
Have you received the Gardasil (HPV) vaccine? __Y __N
Have you ever been on hormone therapy (estrogen/progesteron) __Y __N
Other gynecologic problems/ history: _____
Comments: _____

Pregnancy history (including miscarriages/abortions/ectopic pregnancies):

Month/Year	Sex	Weight	Weeks	Delivery Type	Complications
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____
_____	___	_____	_____	_____	_____

Review of Systems If positive within the last month (circle where appropriate):

___ Abdominal/Pelvic pain
___ Abnormal hair growth
___ Bloating
___ Breast changes/discharge
___ Change in bowel/bladder habits
___ Chest pain
___ Constipation/Diarrhea
___ Coughing/Wheezing
___ Decrease/increase in appetite
___ Dizziness
___ Easy bleeding/bruising
___ Fatigue/Weakness
___ Fevers/Chills
___ Headaches
___ Intolerance to heat/cold
___ Involuntary loss of urine
___ Nausea/Vomiting
___ Shortness of breath
___ Urinary urgency/burning/pain
___ Vaginal discharge/irritation
___ Weight gain/loss

___ Other: _____

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Medications (include dose and frequency, as well as any herbal or vitamin supplements):

_____

_____

Allergies (include reaction and any food allergies):

_____

Medical history (past and present)**:**

___ Anemia
___ Asthma/ Chronic bronchitis
___ Anxiety/Depression
___ Bladder/kidney disease
___ Bleeding disorders
___ Blood clots
___ Cancer: _____
___ Other: _____
___ Domestic violence
___ Diabetes
___ Hearing/vision problems
___ Heart disease
___ Hernia
___ High blood pressure
___ Migraines (with/without aura)
___ Muscles, joint, nerve issues
___ Osteoporosis
___ Psychiatric disorders
___ Seizure disorders
___ Stroke
___ Thyroid disorder

Surgical history (include year and complications if any):

_____

_____

History of a blood transfusion? _____ Reason: _____ Would accept in future? _____

Family History*:

____ Adopted
____ Autoimmune (type): _____
____ Birth defects
____ Bleeding disorder
____ Blood clots
____ Cancer (type): _____
____ Diabetes
____ Heart disease
____ High blood pressure
____ Intellectual disability
____ Osteoporosis
____ Seizure disorder
____ Stroke
____ Thyroid disease

Other: _____

*M= mother, F= father, S= son
D= daughter A= aunt, U= uncle
MGM= maternal grandmother,
MGF=Maternal grandfather,
PGM= Paternal grandmother
PGF= Paternal grandfather

Social History:

Do you live in a safe environment? _____ Do you need help today? _____
Any personal history of physical, emotional, or mental abuse? __Y __N
Any history of alcohol or drug abuse? __Y __N

Alcohol	___ yes	___ No	___ drinks weekly/ monthly (circle one)
Caffeine	___ yes	___ No	___ cups daily
Tobacco	___ yes	___ No	___ cigarettes/ other daily
Drugs	___ yes	___ No	If yes, list: _____
Exercise	___ yes	___ No	Frequency and activity: _____
Seatbelt	___ yes	___ No	

Patient signature: _____ Date: _____