



Women's Healthcare Partners  
Gynecology and Gynecologic Surgery

63 W. Sunbridge Rd.  
Fayetteville, AR 72703  
582-FEMM (3366) Fax: 479-582-5843  
[www.renaissancewomenshealth.com](http://www.renaissancewomenshealth.com)



**New Patient Health Questionnaire**  
Less than 40 years old

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

ALLERGIES: (include reaction i.e. rash, breathing problems)

MEDICATIONS AND DOSAGES: Include vitamins, minerals and herbals supplements.

HEALTH MAINTENANCE: Have you ever had any of the tests/vaccines listed below? When and what was the result?

	Month/ Year	Results	Treatments
Pap test			
Any abnormal paps			
Rubella Antibody Test			
Chicken Pox or the vaccine			
Tetanus-diphtheria booster			
Hepatitis B Vaccine			
Cholesterol test			

SURGERIES: Include dates

MAJOR ACCIDENTS OR INJURIES/HOSPITALIZATIONS – include dates

- \_\_\_ When was the first day of your **last menstrual period**?
- \_\_\_ How many times have you been pregnant?
- \_\_\_ Number of living children
- \_\_\_ Number of Vaginal Deliveries \_\_\_ C-sections
- \_\_\_ How old were you when you started your periods?
- \_\_\_ How often are your periods?
- \_\_\_ How long do you bleed?
- \_\_\_ Are you having problems with your periods?  
If yes, explain \_\_\_\_\_
- \_\_\_ Are you sexually active?
- \_\_\_ What method of birth control are you using?

- \_\_\_ Are you having any **sexual concerns**?
- \_\_\_ Are you worried about **exposure to STDs**?
- \_\_\_ Are you having problems with **pelvic pain**?
- \_\_\_ Are you having frequent or **painful urination**?
- \_\_\_ Do you have any abnormal **vaginal discharge**?
- \_\_\_ Do you have any abnormal **vaginal itching**?
- \_\_\_ Are you having problems with **urine leakage**?
- \_\_\_ Do you smoke? \_\_\_\_\_  
How many a day? \_\_\_\_\_ per day  
For how long? \_\_\_\_\_
- \_\_\_ Do you use alcohol or drugs? \_\_\_\_\_  
How often? \_\_\_\_\_

WHAT ARE YOUR CONCERNS?



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Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Check and date squares below for you and close family members who had any of these diagnoses. If they pertain to you please list date and treatment for condition.

Diagnosis	Self	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alzheimer's									
Asthma									
Alcoholism									
Blood Disease									
Heart Disease									
Cancer									
Brest									
Ovarian									
Other									
Stroke									
Depression									
Developmental delay									
Diabetes									
Hearing Problems									
High Cholesterol									
Mental Illness									
Migraines									
Obesity									
Lung Disease									
Kidney Disease									
Seizure Disorder									
Sickle Cell									
Thyroid Disease									
Breast Disease									
Inherited Disease									
HIV/AIDS									
Blood Clots									
Bleeding problems									
Varicose veins									
Gallbladder problem									
Sexually Transmitted Diseases									
Hepatitis/jaundice									
Headache, chronic									
Fibroids									
Endometriosis									
Bladder problems									
Urinary Tract Infection									

Patient Health History. Explain above marked diagnoses and any additional problems.