Patient Questionnaire

Name_____ Appointment Date_____

Date of Birth_____ Age_____ Sex: ☐ Female ☐ Transgender_____

Please help us provide the best healthcare for you by completing this short questionnaire. Your answers will become part of your medical record.

Current medications/supplements

☐ *Check here if none*

Please list the medications and/or supplements (prescription or over-the-counter) you are currently taking and why:

Name	Dose	Frequency	Prescription or OTC?	Reason?

Medical History

Are you currently or have you been treated in the past for any medical condition? ☐ NO ☐ YES (If yes, please explain)

Current or Past	Condition	Date(s) of treatment
☐ Current ☐ Past		
☐ Current ☐ Past		
☐ Current ☐ Past		

Do you have any drug, nut, or latex allergies ☐ NO ☐ YES (If yes, please explain)

Allergic to	Reaction

Gyn History

Age of your first period? _____ How many days are between each period (example: 28 days) _____

How many days does your flow usually last? _____

Are you currently using birth control? ☐ NO ☐ YES (If yes, please indicate which types)

☐ Pills (brand?)_____ ☐ Condoms ☐ IUD ☐ Depo Provera ☐ Diaphragm

☐ Foam ☐ Norplant ☐ Vasectomy ☐ Essure ☐ Tubal Ligation ☐ Other_____

Have you received the Gardasil vaccine? ☐ NO ☐ YES - Is the series (3 injections) complete? ☐ NO ☐ YES

Date of your last menstrual period_____ Are your periods regular? ☐ NO ☐ YES

Date of your last Pap smear_____ Where was it performed?_____

Date of your last HPV test_____ Where was it performed?_____

Have you ever had an abnormal pap smear? ☐ NO ☐ YES (If Yes, please indicate date(s)_____

Are you currently sexually active? ☐ NO ☐ YES Have you ever had an STD? ☐ NO ☐ YES

Date of your last mammogram_____ Where was it performed?_____

Date of your last bone density test_____ Where was it performed?_____

Date of your last colonoscopy_____ Where was it performed?_____

Pregnancies

Have you ever been pregnant? ☐ NO ☐ YES If yes, please list the details of your pregnancies (including miscarriages & abortions)

	Date of Pregnancy	Type of Delivery (vaginal, C/S, VBAC, miscarriage or abortion)
Pregnancy #1		
Pregnancy #2		
Pregnancy #3		
Pregnancy #4		

Surgical History

Have you ever had any surgeries? ☐ NO ☐ YES (If yes, please explain)

Date of surgery Surgery Type

Hospitalizations

Have you been hospitalized for any other reasons? ☐ NO ☐ YES (If yes, please explain)

Family History

Please indicate your family members' statuses as well as their history of any of the following:

	Alive or deceased?	Indicate if healthy	Ovarian Cancer	Breast Cancer	Colon Cancer	Diabetes	High blood pressure	Heart disease	Blood clots	Osteo-porosis
Mother			☐	☐	☐	☐	☐	☐	☐	☐
Father				☐	☐	☐	☐	☐	☐	☐
Siblings			☐	☐	☐	☐	☐	☐	☐	☐
Children			☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather				☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather				☐	☐	☐	☐	☐	☐	☐

How many brothers do you have?_____ Sisters?_____

How many sons do you have?_____ Daughters?_____

Social History

Do you drink alcohol? ☐ NO ☐ YES (If yes, please indicate how much)_____

Do you smoke? ☐ NO ☐ YES (If yes, how many packs per day?)_____

Do you use street drugs or recreational drugs? ☐ NO ☐ YES (If yes, please explain)_____

Do you exercise regularly? ☐ NO ☐ YES (If yes, please explain)_____

Do you have a current partner? ☐ NO ☐ YES (If yes, for how long?)_____

Have there been any changes in your personal relationships? ☐ NO ☐ YES (If yes, please explain)_____

Do you have any problems at home? ☐ NO ☐ YES (If yes, please explain)_____

Do you have questions regarding safer sex? ☐ NO ☐ YES

Do you have any eating disorders? ☐ NO ☐ YES (If yes, please explain)_____

Are you currently employed? ☐ NO ☐ YES

Is there any additional information you would like to share with your provider regarding your medical history? (Attach additional pages as needed): _____

Thank you!

New Patient Information Form

Thank you for choosing Baystate Ob/Gyn Group, Inc. for your care!

First Name_____ Last Name_____ Appointment Date_____

1. We'd like to send you periodic informative emails about upcoming seminars, women's health, and news about our practice. Please provide your email address below. (If you decide to decline our emails at a later date, the opportunity to "opt out" is included in each email.)
   EMAIL: _____

2. Please tell us how you heard about our practice. (If you have more than one source, please tell us how you first heard about us) :
   - ☐ Employee from Baystate Ob/Gyn Group
   - ☐ Employee from Baystate Medical Center (list department)_____
   - ☐ Primary care physician or other health professional (please provide full name of the provider)
     _____
   - ☐ Referral service through Baystate Medical Center ("The Professionals")
   - ☐ A friend or family member recommended our practice to you
   - ☐ Newspaper article about our practice or one of our providers
   - ☐ Insurance directory of in-network providers
   - ☐ Yellow pages
   - ☐ Internet search
   - ☐ Saw a sign for the practice outside of one of our offices
   - ☐ You were a patient of the provider you are seeing from his or her previous practice
   - ☐ Other (please specify)
   - ☐ Advertisement in locate newspaper (please provide the name of the newspaper)_____
   - ☐ Saw our ad at a local event, health fair, or workshop (please name the event)_____