

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?	Condition	Date(s) of treatment
<input type="checkbox"/> Current <input type="checkbox"/> Past	_____	_____
<input type="checkbox"/> Current <input type="checkbox"/> Past	_____	_____
<input type="checkbox"/> Current <input type="checkbox"/> 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	Osteoporosis
Mother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandmother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Grandfather				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandmother			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal Grandfather				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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!



Routine Gynecological Exam Acknowledgement

Patient Name _____ Date of Birth _____

I acknowledge and understand that the appointment I have scheduled today (_____) is a **routine gynecological exam**. I also understand that today's visit will be billed to my insurance company as such, with a routine diagnosis. **I acknowledge and accept that some insurance companies (which may include my present health insurance company) do not cover annual exams for a number of reasons, including but not limited to their annual exam frequency policy.** I also understand that it is my responsibility to know the policies of my insurance company, and that Baystate Ob/Gyn group Inc. is not responsible for knowing what my insurance policy will and will not cover.

Patient signature

Date

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) _____