Appointment Date:_____ Time:_____ Fuoss, LaBuda, DiCenzo, Cirucci, Santerini, McIntyre, Silverman

☐ Sewickley
301 Ohio River Blvd. Suite 301 (412)741-6530

☐ Moon
1009 Beaver Grade Rd. (412)264-2450

Premier
Women's Health

**Annual Gynecological Examination Health Questionnaire and New Patient Information Request**

Name _____ Marital Status_____ Age_____ Date_____

Address _____ City_____ State/Zip_____

Home Phone_____ Work Phone_____ Cell_____

Email Address _____ Primary Care Physician _____

Date of Birth_____ Social Security Number_____

Employer_____ Occupation_____

Emergency Contact_____ Phone_____

How many pregnancies have you had?_____ How many live births?_____

**PLEASE CIRCLE YES OR NO:**

YES NO Do you have periods? How many days apart?_____ Date of last period?_____
YES NO Are your periods regular?
YES NO Are your periods heavy?
YES NO Do you have bleeding between your periods?
YES NO Are you sexually active?
YES NO Do you currently have an abnormal vaginal discharge, odor, or itching?
YES NO Do you want to be tested for HIV?
YES NO Do you have pain with intercourse?
YES NO Are you troubled with leakage of urine?
YES NO Have you ever had a sexually transmitted disease?
YES NO Do you want to be tested for STDs (Chlamydia, Gonorrhea)?
YES NO Have you ever had an abnormal pap test?
YES NO Do you have concerns regarding physical, sexual, or emotional violence at home?
YES NO Have you had the Gardasil (HPV) vaccine series?
YES NO Do you smoke? If yes, how much per day? _____
YES NO Do you drink alcohol? If yes, how often? _____

**Have you had any new medical problems or surgeries since your last visit? If so, please elaborate.**

_____

_____

**Please list all medications including vitamins and herbal supplements:**

_____

_____

_____

**Please list any allergies to medications:**

_____

_____

_____

Name _____ Date of Birth _____

**Have any of your family members (blood relatives) had any new medical problems since your last visit? If so, please explain:**

_____

_____

**When was your last mammogram?** _____

**When was your last osteoporosis screening test?** _____

**When was your last screening stool test or colonoscopy?** _____

**Are you currently experiencing any of the following? If yes, circle and explain.**

| SYMPTOMS | YES | NO | If you answered YES, please explain: |
|---|---|---|---|
| 1. **Constitutional:** weight loss, fatigue, fever | | | |
| 2. **Eyes:** visual changes, blurred vision | | | |
| 3. **Ears, Nose, Mouth, Throat:** hearing loss, nosebleeds | | | |
| 4. **Cardiovascular:** chest pain, swelling in extremities | | | |
| 5. **Respiratory:** shortness of breath, chronic cough, wheezing | | | |
| 6. **Gastrointestinal:** diarrhea, constipation, blood in stool, nausea, vomiting | | | |
| 7. **Genitourinary:** pain with urination, frequency of urination, leakage of urine | | | |
| 8. **Musculoskeletal:** back pain, neck pain | | | |
| 9. **Neurological:** headaches, numbness, dizziness, seizures | | | |
| 10. **Psychiatric:** depression, anxiety, frequent crying | | | |
| 11. **Endocrine:** heart palpitations, unexplained weight gain, heat or cold intolerance | | | |
| 12. **Skin:** rash, breast lumps | | | |
| 13. **Blood/Lymph:** swollen glands, excessive bleeding | | | |
| 14. **Allergy/Immunology:** allergic reaction, frequent infections | | | |