

Appointment Date: _____ Time: _____

Fuoss, LaBuda, DiCenzo, Cirucci, Santerini,
McIntyre, Covatto, Silverman

Sewickley

Moon

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

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Pharmacy _____

*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? Male Female Both

If yes, method of birth control? Pill Tubal Essure IUD Ring

Implant Vasectomy Other _____ None

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, vape, or use smokeless tobacco? 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			