Ferns, Matile, Perryman & Moore, MD's, PC

Patient ID#_____

NEW PATIENT
COMPREHENSIVE PATIENT QUESTIONNAIRE

Name_____ Date of Birth_____ Age_____ Today's Date_____
Primary Care Provider_____
Do you want a nurse present during your exam? (circle one) **YES** **NO**

SOCIAL HISTORY

(circle one) Single Married Separated Divorced Widowed
Alcohol (circle one) YES NO Type_____ How much_____ # of years_____
Tobacco (circle one) YES NO How much_____ # of years_____ Ever quit before_____
Recreational Drugs (circle one) YES NO Type_____ How much_____ # of years_____
Your occupation_____

OBSTETRIC HISTORY

Total # of pregnancies_____ # of live births_____ # of premature births_____ # living children_____
miscarriages_____ # elective abortions_____

# Preg	Birthdate	Wks Preg	Wt	Sex	Type of Delivery	Notes	# Preg	Birthdate	Wks Preg	Wt	Sex	Type of Delivery	Notes
1							4						
2							5						
3							6						

GYNECOLOGY HISTORY & REVIEW OF SYSTEMS

Age of 1st period_____ Age of menopause_____
First day of your last menstrual period_____ # of days between periods_____
How many days do you flow_____ Use Tampons?_____ Pads?_____
Do you have painful periods_____ light periods_____ moderate periods_____ heavy periods_____
What relieves your cramps?_____
Date of last pap smear_____ Where_____ Result_____
Have you ever had an abnormal pap?_____ When_____ Treatment_____
Have you had cervical dysplasia (pre-cancer)_____ When_____ Treatment_____
Do you do self breast exams?_____ Date of last mammogram_____ Result_____
Have you ever had a breast biopsy?_____ When_____ Result_____
Date of last Bone Density_____ Date of last Colonoscopy_____
Have you ever been sexually active?_____ Are you now?_____ Age of 1st sexual experience_____
New partner is past 6 months?_____ # of lifetime sexual partners_____
Sex with Males_____, Females_____, or both_____
What are you using for birth control now? (please circle) Foam Condoms IUD Implant Diaphragm
Tubal Ligation Vasectomy Birth Control pill Vaginal Ring Withdrawal Natural Family Planning
Other_____
Have you had all three of the Gardasil or Cervarix (HPV) Vaccines?_____
Do you feel safe at home & in your relationships?_____
Do you exercise?_____ What exercise do you do?_____
Do you wear your seatbelt?_____ Sunscreen?_____ Smoke Detectors at home?_____

(Continued on back of page)

MEDICAL HISTORY

Do **YOU** have or have you ever had (please circle & include details if pertinent):

Breast Lumps	Hair Falling Out	Drug Problem	Anxiety
Breast Pain	Difficulty Sleeping	Alcohol Problem	Tension
Nipple Discharge	Mood Changes/Irritability	Liver Disease/Hepatitis	Anemia
Breast Cancer	Memory Loss/Mental Confusion	Gallbladder Problems	Nausea
Genital Warts	Personality Disorder	Colitis/Diverticulitis	Vomiting
Genital Herpes	Mental Illness	Reflux/GERD/Ulcer	Cough
AIDS Test	Depression	Bowel Incontinence	Diarrhea
Chlamydia/Gonorrhea	Headache, non-migraine	Blood in Stools	Constipation
Vaginal Discharge	Migraines	High Cholesterol	Weight Loss
Vaginal Dryness	Epilepsy/Seizures	Diabetes, type_____	Weight Gain
Painful Intercourse	Bleeding Disorder	Cancer of _____	Fatigue
Decreased sex drive/libido	Blood Transfusion	Thyroid Problem_____	Glaucoma
Difficult to climax sexually	Blood Clotting Disorder	Kidney Disease	Lupus
Urinary Incontinence	DVT (blood clot)	Chronic Lung Disease	Asthma
Urinary Urgency/Frequency	Skin Problem/Mole Changes	Swelling all over the body	Night Sweats
Painful Urination	Cold/Heat Intolerance	Arthritis/Joint Pain	Infertility
Blood in Urine	Ectopic Pregnancy	Osteoporosis	Abuse_____
Endometriosis	Mitral Valve Prolapse	Shortness of Breath	
Uterine Fibroids	Heart Murmur	Heart Disease	

Other_____

Do you take antibiotics for dental procedures?_____ Do you have dental caps, plates, or dentures?_____

Have you had trouble with anesthesia in the past?_____ Explain_____

***DRUG ALLERGIES & REACTIONS**_____

PREFERRED PHARMACY (name, location, phone #)_____

MEDICATIONS (include vitamins, over-the-counter meds, herbal supplements, troches, etc.:

Name	Dose	Reason	Prescriber

SURGICAL HISTORY (type, date); (example: appendix 2007; C-Section 2003; Gallbladder 1999; Tonsils 1990)

_____

_____

_____

FAMILY HISTORY (mother, father, siblings, aunts/uncles, grandparents) **Please note if maternal or paternal**

High Cholesterol, *Who?*_____ Heart disease , *Who?*_____ Arthritis,*Who?*_____

Cancer of Uterus, *Who?*_____ Kidney disease, *Who?*_____ Diabetes, *Who?*_____

Cancer of Ovaries, *Who?*_____ Anesthetic Problems, *Who?*_____ Stroke, *Who?*_____

Cancer of Breast, *Who?*_____ High Blood Pressure, *Who?*_____ Lupus, *Who?*_____

Cancer of Colon, *Who?*_____ Blood Clotting Disorder, *Who?*_____ Mental Illness, *Who?*_____

Other Cancer, *Who?*_____ Bleeding Disorder, *Who?*_____ Asthma, *Who?*_____

I have answered this completely & to the best of my knowledge.

Signature_____ **Date**_____