HENDERSON AND WALTON WOMEN'S CENTER, P.C.
NEW PATIENT QUESTIONNAIRE

NAME _____ **AGE** _____ **DATE** _____

MARITAL STATUS ❑ Married ❑ Single ❑ Divorced ❑ Widowed

WHO IS YOUR FAMILY PRACTICE PHYSICIAN/INTERNIST? _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? Name _____ **Patient of HWWC?** ❑ Yes ❑ No

Please list current medications including dosage and frequency:

NAME OF MEDICATION	DOSAGE	FREQUENCY TAKEN

SEASONAL VACCINES THIS YEAR ❑ Pneumonia ❑ FLU **HAVE YOU EVER HAD THESE VACCINES?** ❑ Shingles ❑ TDAP ❑ Gardasil

PLEASE LIST ANY/ALL DRUG ALLERGIES: _____

PATIENT HISTORY: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

(Check all that apply)

❑ Heart Disease ❑ Hypertension ❑ Mental Illness
❑ Diabetes ❑ Genetic Disease ❑ Kidney Disease
❑ Seizure Disorder ❑ Anemia ❑ Lung Disease
❑ Drug Use ❑ Smoking ❑ STD(sexually transmitted disease)
❑ Alcohol Use:_____ Socially_____ Frequently_____ Rarely

When was your most recent pap smear? _____

When was your most recent mammogram? _____

FAMILY HISTORY: LIST YOUR IMMEDIATE FAMILY MEMBERS THAT HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

(Check all that apply)

❑ Heart Disease _____ ❑ Seizure Disorder _____
❑ Diabetes _____ ❑ Cancer _____
❑ Mentally Challenged _____ ❑ Kidney Disease _____
❑ Anemia _____ ❑ Mental Illness _____
❑ High Blood Pressure _____ ❑ Multiple Pregnancy _____
❑ Genetic Disease _____ ❑ Infertility _____
❑ Blood Clots/Stroke _____ ❑ Other _____

When was your most recent colonoscopy? _____ **What were the results?** ❑ Normal ❑ Abnormal

When was your most recent Bone Density? _____ **What were the results?** ❑ Normal ❑ Abnormal

Please list all surgeries: _____

GYNECOLOGICAL HISTORY

What was the first day of your last period? _____ **How long do your periods last?** _____

How many days apart are your menstrual cycles starting from day one of your cycle to the first day of your next cycle? _____

Menstrual Flow: ❑ Light ❑ Moderate ❑ Heavy **Do you have:** ❑ Cramping ❑ Heavy Clotting ❑ Mood Swings

What age did you start having your period? _____ **Are they monthly?** _____ **Are you still having regular periods?** _____

If menopausal, age at menopause _____ **Have you ever had a blood transfusion?** _____

Are you sexually active? ❑ Yes ❑ No ❑ Never

PREGNANCY HISTORY

Total # of pregnancies ____ Live Term Births ____ Abortions ____ Premature Births ____ Miscarriages ____ Stillbirths ____
Ectopic Pregnancies ____ Previous C-Section ____

What method of birth control do you currently use? Check all that apply: ❑ Pills ❑ Patch ❑ Ring ❑ Condom ❑ IUD ❑ Tubes Tied
❑ Nothing ❑ Essure ❑ Spermicide ❑ Withdrawal ❑ Timing ❑ Shots ❑ Vasectomy ❑ Nexplanon

PATIENT SIGNATURE: _____