Marc L. Chaiken, M.D. & Associates   Columbia Surgery Center, Inc.
Gynecology and Minimally Invasive Surgery
11055 Little Patuxent Parkway, Suite 106 Columbia, MD 21044

New Patient Health Questionnaire

Name: ____

Address: ____

Date of Birth: ____

First day of last menstrual period: ____

What is the reason for this visit? ____

Are you or your partner currently using any method of birth control?
Circle one or write details:
Pills, patch, injections, ring, diaphragm, condoms, IUD, tubal ligation, hysterectomy, vasectomy

How many full term pregnancies have you had? ______________________________
How many times have you delivered prematurely? _____________________________
How many abortions or miscarriages have you had? ___________________________
How many living children do you have? _____________________________________
Have you had any complications of pregnancy or childbirth? ____________________

Y ____ N____ Have you had any irregular bleeding?
Y ____ N____ Do you have high blood pressure?
Y ____ N____ Do you have any kind of breast disease?
Y ____ N____ Have you ever had blood clots in your legs or phlebitis?
Y ____ N____ Have you ever had gallbladder disease?
Y ____ N____ Have you ever had a liver disease?
Y ____ N____ Have you ever had a stroke or heart attack?
Y ____ N____ Have you ever had cancer of the breast or uterus or ovary?
Y ____ N____ Do you have vaginal bleeding not associated with a period?
Y ____ N____ Have you ever had fibroid tumors of the uterus?
Y ____ N____ Do you have seizures/migraines/kidney disease?
Y ____ N____ Do you have diabetes?
Y ____ N____ Do you have vaginal dryness?
Y ____ N____ Do you have hot flashes/night sweats?
Y ____ N____ Do you now or have you ever taken hormone replacement therapy?

Please continue questions on reverse side.

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Past medical history:
List any important medical problems and surgeries:

Your Family History: Does anyone in your family have:

Diabetes?	Y____	N____
High blood pressure?	Y____	N____
Breast Cancer?	Y____	N____
Other types of cancer?	Y____	N____
Heart attack or stroke (at a young age)?	Y____	N____

Are you allergic to any medicines? Y____ N____
If yes, what medicines are you allergic to: ____

Do you smoke? Y____ N____ How many packs per day __________________________

What medicines are you taking now? ____
____

Do you know how to do a breast exam? Y____ N____

Have you ever had a mammogram? Y____ N____
When? ___________________________ Where? ____________________________________

Menstrual History:
Age at first period ___________________
Interval between periods ______________
Duration of each period _______________
Do you have pain or cramps with periods? Y____ N____

Do you have any of the following now?

Vaginal discharge?	Y____	N____
Vaginal itching?	Y____	N____
Bleeding between periods?	Y____	N____

Did your mother take DES when she was pregnant with you? (Diethylstilbesterol is a hormone given to prevent miscarriages in the first three months of pregnancy).
Y____ N____ I do not know ____

Have you ever had an abnormal PAP smear? Y____ N____

Have you ever been treated for sexually transmitted disease? Y____ N____
Circle any that apply: gonorrhea, chlamydia, syphilis, genital warts
Have you ever had PID (pelvic inflammatory disease)? Y____ N____