Franciscan PHYSICIAN NETWORK

NEW PATIENT QUESTIONNAIRE

The location of your appointment is: ☐ Franciscan Physician Network - Obstetrics & Gynecology - Lafayette
3920 St Francis Way, Lafayette IN 47905

☐ Franciscan Physician Network - Obstetrics & Gynecology - Crawfordsville
1630 Lafayette Road, Suite 400, Crawfordsville IN 47933

Thank you for selecting us to take part in your medical care. We always strive to give the best care possible. It would help us if you would complete this questionnaire prior to your appointment. The information contained in here will be kept strictly confidential and will not be released to anyone without your written authorization. If you have any questions, don't hesitate to contact our office. **Please arrive 15 minutes before your scheduled appointment**. We look forward to seeing you.

Name:____ Birthdate:__________________

Date of appointment:____________________ with Physician/Nurse Practitioner:____________________

What is (are) your primary reasons for this appointment?

PROBLEM	HOW LONG PRESENT	WHAT YOU HAVE TRIED

MENSTRUAL HISTORY

IF NOT POST-MENOPAUSAL (if still having periods):

1. Age first period began:____
2. First day of last menstrual period:____________________________________
3. Was it a normal period?.. YES NO
4. Are your periods regular?.. YES NO
5. Do you have any bleeding between periods?.. YES NO
6. Is cramping a problem?... YES NO
   If yes, what have you tried for the cramps:
   Name of medication:____________________________ strength:________________
   How often:____________________ how successful is treatment:____________________
7. How many days usually pass from the start of one period to the start of the next?__________________
8. How long do your periods last?____________________________________
9. On the heaviest day, how often do you have to change a pad or tampon because is it soaked? Every__________

Name:______________________________ DOB:______________

IF POST-MENOPAUSAL (not having periods):

1. When was your last menstrual period?______________________________

2. Any bleeding since menopause?______________________________

3. Have you ever taken any post-menopausal hormones such as pill, cream, patch(estrogen, progestin, etc)?………………… YES NO
   If yes, what?______________ when?______________ thru ______________

PAP HISTORY

1. Date of last pap smear:______________________________

2. Have you ever had any abnormal paps?……………………………………………………………………………………………….. YES NO
   If yes: when was it?______________________________
   What did the abnormal pap show?______________________________
   How was it evaluated?______________________________
   Have you had regular pap smears since then?……………………………………………………………………….. YES NO

CONTRACEPTIVE HISTORY

Please list all the contraceptive methods you have used. Possible methods include: sexual partner's vasectomy, tubal sterilization, birth control pills, contraceptive implants (ie Implanon), Depo Provera shot, IUD, diaphragm, condoms, spermicide (foam, suppository, sponge), "rhythm" (calendar, temperature, and/or mucous methods), or withdrawal.

METHOD	DATES WHEN USED	ANY PROBLEMS WITH METHOD
	Thru	
	Thru	
	Thru	
	Thru	

BREAST CANCER SCREENING

1. Do you check your breasts for lumps?……………………………………………………………………………………………. YES NO
   If yes, how often?______________________________

2. Have you ever had a mammogram?…………………………………………………………………………………………………. YES NO
   If yes, when was the most recent one?______________________________
   Where was the most recent one done?______________________________

PREGNANCY HISTORY

(including miscarriages, abortions, or tubal pregnancies, etc)

DATE	HOSPITAL	M.D.	GEST. AGE	SEX	WT	BABY'S NAME	DURATION OF LABOR	TYPE OF DEL/ REMARKS

Name:____ DOB:_________________________

PAST MEDICAL HISTORY

Hospitalizations and surgeries:

DATE	WHERE	DIAGNOSIS AND/OR PROCEDURE	COMMENTS

MEDICAL HISTORY: DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING:

	YES	NO	COMMENTS
1. Severe or migraine headaches			
2. Thyroid problems			
3. Heart murmur			
4. Other heart problems			
5. Cholesterol checked			When? Results
6. Asthma			
7. Other lung problems			
8. High blood pressure			
9. Diabetes			
10. Blood transfusions			When?
11. Blood clots in legs or lungs			
12. Phlebitis			
13. Varicose veins			
14. "Colitis", irritable bowel or spastic colon			
15. Other bowel problems			
16. Liver problems (eg hepatitis)			
17. Gallstones			
18. Kidney stones			
19. Seizures, epilepsy, or convulsions			
20. Stroke			
21. Nervous breakdown			
22. Severe depression			
23. Panic attacks			
24. Other nervous or mental disorders			
25. Breast cancer			
26. Endometrial (uterine lining) cancer			
27. Endometriosis			
28. Pelvic infection, tubal infection, PID (pelvic inflammatory disease)			
29. Genital herpes			
30. Genital warts			
31. Gonorrhea			
32. Chlamydia			
33. Syphilis			
34. AIDS or positive HIV test			
35. Birth defects or any inherited disease			

Name:____ DOB:____________________

CONT'D	YES	NO	COMMENTS
36. Measles or the vaccine			
37. German measles (Rubella) or the vaccine			When?
38. Chicken pox			
39. Tetanus booster			When?
40. Human Papilloma vaccine (HPV)			When?
41. Colonoscopy			When?
42. Bone Densitometry Scan			When?
43. Other health problems			

MEDICATIONS

(include prescription, nonprescription, and herbal)

NAME	STRENGTH	HOW OFTEN TAKEN	PRESCRIBING DOCTOR (if any)	REASON FOR TAKING

List medications you cannot take for any reasons (eg allergies):

NAME OF MEDICATION	REACTION

FAMILY HISTORY

Please list, if any, blood relatives that have any of the following problems:

HEALTH PROBLEMS	RELATIONSHIP TO YOU(mother,sister,ect.)	HOW OLD THEY WERE WHEN DIAGNOSED
Breast cancer		
Ovarian cancer		
Colon cancer		
Other cancer (type)		
Osteoporosis (broken hip or wrist, collapsed vertebra, or "Dowager's hump")		
Diabetes		
Heart attacks		
Stroke		
High cholesterol		
Other (eg genetic disease such as hemophilia, other inherited bleeding tendencies, cystic fibrosis, muscular dystrophy, inherited anemia, etc)		

Name:____ DOB: ________________________

REVIEW OF SYSTEMS: Have you recently been troubled with any of the following:

GENERAL HEALTH:	YES	NO	**GENITOURINARY:**	YES	NO
Unexplained weight loss			Pain with urination		
Unexplained weight gain			Blood in urine		
Fever			Frequent urination		
Fatigue			Urine loss with strong urge to void		
Hot flashes			Urine loss with cough/sneeze/laugh		
			Incomplete emptying of bladder		
EARS/NOSE/MOUTH/THROAT:			Pain with or after sex		
Unusual or frequent headaches			Bleeding with sex		
Hearing loss			Vaginal dryness with intercourse		
Ringing in ears			Low sex drive		
			Abnormal vaginal discharge		
EYES:			Vaginal itching and/or burning		
Visual changes			Foul vaginal odor		
BREAST:			**MUSCULOSKELETAL:**		
Mass/lump in breast(s)			Weak muscles		
Nipple discharge			Joint pain		
			Back pain		
CARDIOVASCULAR:					
Chest pains			**SKIN:**		
Palpitations			Changing or new moles		
RESPIRATORY:			**NEUROLOGIC:**		
Wheezing			Faintness		
Cough up blood			Numbness or tingling in legs or arms		
Persistent cough					
Difficulty breathing			**PSYCHIATRIC:**		
			Severe anxiety		
GASTROINTESTINAL:			Depressed feeling		
Diarrhea			Crying spells		
Blood in stools			Feel like committing suicide		
Constipation(infreq and/or hard stools)					
Stomach and/or pelvic pain			**ENDOCRINE:**		
Fecal incontinence			Excessive thirst		
Nausea			Heat intolerance		
Vomiting			Cold intolerance		
Abdominal enlargement			Excessive hair growth (ie face)		
Indigestion					
Loss of appetite			**LYMPHATIC/BLOOD:**		
			Excessive bleeding when cut		
			Easy bruising		
			Swollen lymph nodes or glands		

Name:______________________________ DOB:______________________

SOCIAL HISTORY:

1. What is your occupation (including student, homemaker, unemployed, disability, etc.)?______________
   ____

2. What is your educational background?_______________________________________

3. What is your current marital status? (circle all that apply)
   Married Widowed Separated Living Together
   Single Engaged Divorced

4. What is your partner's occupation?____

5. Do you feel you are under too much stress (eg. due to family, finances, work, etc.)?...........YES NO

6. Do you do any kind of regular physical exercise?...YES NO
   If yes, what kind of exercise?____
   how often do you exercise?____
   how long do you exercise each time?___________________minutes.

7. On the average, how many servings of the following do you eat/drink per day:
   Caffeine containing beverages (coffee, tea, caffeine containing "pop", chocolate)___________servings.
   Decaffinated coffee or tea (NOT including herbal tea)?________________servings.

8. How many servings of alcoholic beverages would it take to get you "tipsy"?______________
   On the average, how much alcohol do you drink?____________drinks per_______________

9. Do you smoke tobacco?..YES NO
   If yes, how many packs per day?____

10. On the average, how many servings of the following calcium containing foods do you have per day?

	SERVING SIZE	NUMBER OF SERVINGS	CALCIUM per SERVING		TOTAL CALCIUM
Cheese	1 oz.		X 200	=	
Milk, custard, soup, or Pudding made with milk	1 cup		X 300	=	
Yogurt	1 cup		X 400	=	
Cottage Cheese	1 cup		X 200	=	
Calcium Tablets				=	
			TOTAL PER DAY	=	

Name:____ DOB:________________________

SENSITIVE QUESTIONS:

As with the rest of the questionnaire, all these questions are strictly confidential and used only to help care for your health. You do not have to answer any questions that make you uncomfortable.

1) Have you ever used any street drugs?..YES NO
(This is strictly confidential and for health care purposes only)
If yes, please list below:

TYPE OF DRUG	HOW USED (smoke, "snort", "shoot up")	HOW MUCH	HOW OFTEN	LAST USED

2) Have you ever been forced or coerced into having sex against your will?.............................YES NO

3) Have you ever been physically abused?...YES NO

4) Have you ever had sexual intercourse?..YES NO

If yes, how many sexual partners have you had in your life?____________________________

5) Are you currently sexually active?..YES NO

If no, when did you last have sexual intercourse?______________________________________

If yes, how long have you been with your current sexual partner?________________________

6) Do you believe your current sexual relationship has been monogamous (you have sex only with your partner and they have sex only with you)?..YES NO