Ray P. Kamali MD FACOG

New Gynecology Patient Questionnaire

Date: _____

Name: _____ Birthdate: _____

Age: ____ Whom may we thank for referring you? _____

1. When was the first day of your last normal menstrual period? _____
   a. How often do you have a period (ie. every 4 weeks)?_____
   b. Are they [ ] light [ ] moderate or [ ] heavy

4. Are you allergic to any medications? [ ]Yes [ ]No Are you allergic to latex? [ ]Yes [ ]No

If yes, explain which medication(s) and what type of reaction: _____

5. List of your medications, including non-prescription, herbal remedies, and vitamins with doses.

6. Do you smoke? [ ]Yes [ ]No. If yes, how many cigarettes per day?_____

Do you drink alcohol? [ ]Yes [ ]No. If yes, what type and how much per week? _____

Do you use illegal drugs? [ ]Yes [ ]No. If yes, what time and how often? _____

What type of exercise do you get?_____ How often?_____

7. Do you have any medical problems or any history of medical problems (ie. High blood pressure, cancer, thyroid disease)?_____

_____

_____

Check any of the problems that you or an immediate family member has?

	Self	Family member, who?
Heart disease or high blood pressure		
Diabetes		
Breast Cancer		
Ovarian or Uterine Cancer		
Other Cancer		
Blood Clots		

	Self	Family member, who?
Osteoporosis		
Asthma		
Seizures		

8. Have you ever had any of the following?

	Yes or No	When?
Abnormal Pap smear		
Sexually Transmitted disease		

9. List all surgeries you have had.

Surgery	When?	Why?

10. Have you been hospitalized for any reason other than childbirth and above listed surgeries? If yes, explain when and why._____

_____

11. Please fill out below table regarding any pregnancies.

Pregnancy	Date	Outcome (miscarriage, ectopic, vaginal delivery or C-section)
1st		
2nd		
3rd		
4th		
5th		

12. When was your last?

Pap_____ Result_____

Mammogram_____ Result_____

Colonoscopy_____ Result _____

Flu shot_____

Tetanus shot_____