Kamali OBGYN

New Patient Questionnaire

Name: Age: Date:

Reason for your visit:
What brings you into the office today? Are there any concerns you would like to address today?

Current Medication:
What medications are you currently taking?

Name Dosage Frequency
Name Dosage Frequency
Name Dosage Frequency
Name Dosage Frequency

Allergies:
Are you allergic to any medication?

Name Reaction Latex Y / N Tape Y / N
Name Reaction Iodine Y / N Other:

Past Medical History: (Circle all that apply)

Alcoholism	Back Problems	Ear Problems	Hepatitis- A,B or C	Measles	Skin Disorder
Allergies	Bleeding Disorder	Eating Disorder	High Blood Pressure	Migraines	Stomach Ulcer
Anemia	Blood Disease	Epilepsy	High Cholesterol	Osteoporosis	Substance Abuse
Anxiety Disorder	Blood Transfusion	Glaucoma	Joint Disorder	Pneumonia	Thyroid Disorder
Arthritis	Cancer	Gout	Kidney Disorder	Polio	Tuberculosis
Asthma	Diabetes	Heart Disease	Liver Disorder	Rheumatic Fever	Venereal Disease
Aids / HIV	Depression	Heart Problems	Lung Disease	Stroke	

When was your last: PAP Mammogram Colonoscopy

Have you ever been hospitalized or had surgery? (excluding pregnancy)

Year Reason Year Reason
Year Reason Year Reason

Social History:

Do you use street drugs? Y / N Which ones #of times per week?
Do you smoke? Y / N #of years #of packs per day
Do you drink caffeine? Y / N # of drinks/ day
Do you drink alcohol? Y / N # drinks/ week Do you Exercise? Y / N
Are you sexually active? Y / N # of partners Do you feel safe at home? Y / N

Kamali OBGYN

Name: Age: Date:

Gyn History:

- □ Abnormal Uterine Bleeding
- □ Abnormal Pap Smear
- □ Bleeding between periods
- □ Breast Lump
- □ Breast Lump
- □ Breast Surgery
- □ Cervical Cancer
- □ Chlamydia
- □ Colposcopy
- □ Cryosurgery
- □ DES Exposure
- □ Extreme Menstrual Pain
- □ Fibroids
- □ Genital Warts
- □ Gonorrhea
- □ Herpes
- □ Hot Flashes
- □ HPV
- □ Infertility
- □ Irregular Periods/Bleeding
- □ Nipple Discharge
- □ Ovarian Cysts
- □ Ovarian Cancer
- □ Painful Intercourse
- □ Pelvic Inflammatory Disease
- □ Uterine Cancer
- □ Urinary Incontinence
- □ Yeast Infections - Frequent

Menstrual History:

At what age did you have your 1st period?_____ How often does your period occur?_____ days

When was the 1st day of your last period? How long does your period last? days

Is your period irregular? Y / N Do you get cramps? Y / N ___Mild ___Moderate __Severe

Menopausal Y / N ___Pre ___Post Have you had a Hysterectomy? Y / N If yes, When? _____

Contraceptive History:

Current Method: _____ Past Methods: _____

Obstetrical History:

Total # pregnancies:_____ # Full term _____# Premature _____# of Abortions _____#of Miscarriages _____

Where there any complications associated with any of your pregnancies?

_____

_____

Past Pregnancies:

	Date	Length of Pregnancy	Type of Delivery	Sex	Weight	Living
1						
2						
3						
4						
5						