Northwestern Medicine®

Minimally Invasive Gynecologic Surgery Program at Northwestern

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete all sections on pages 1 to 5. This information will help us to evaluate your care needs and streamline your initial visit to the Minimally Invasive Gynecologic Surgery Program at Northwestern.

1. Patient Demographics and Overview

Date: ____________________ **Height:** ____________

Patient Name: ____________________ **Weight:** ____________

Date of Birth: ____________________ **Age:** ____________

Others who provide your healthcare:

Referring Physician

Phone number and/or address (if not at Northwestern): ____________________

Primary Care Physician

Phone number and/or address (if not at Northwestern): ____________________

Other Physician(s)

Phone number and/or address (if not at Northwestern): ____________________

I am seeking care for the following problems: ____________________

____

____

2. Personal Past Gynecologic Medical History

Please indicate your past gynecologic medical history in the table below.

	Date	Normal	Abnormal	Never
Last Pap Smear				
Last Mammogram				
Last Colonoscopy				

Please indicate any forms of current contraception; (including vasectomy or tubal ligation): ______________________________

____

Are you currently sexually active: ☐ Yes ☐ No

Please check and describe the following Personal Gynecologic Medical Conditions that apply:

☐ Painful Periods: ______________________________

☐ Heavy Periods: ______________________________

☐ PMS: ______________________________

☐ Fibroids: ______________________________

☐ Endometrial Polyps: ______________________________

☐ Endometriosis: ______________________________

☐ Problems with Intercourse: ______________________________

☐ Urinary Leaking: ______________________________

☐ Incontinence of Stool: ______________________________

☐ Sexually Transmitted Diseases (STDs) / STIs: ______________________________

☐ Fertility Problems: ______________________________

☐ Abnormal PAP smears and treatment:______________________________

☐ Menopause Symptoms: ______________________________

3. Personal Past Medical History

Please indicate your past medical history in the table below.

☐ Cancer: ______________________________

☐ Migraines: ______________________________

☐ Heart Disease: ______________________________

☐ Diabetes: ______________________________

☐ High Blood Pressure: ______________________________

☐ High Cholesterol: ______________________________

☐ Thyroid Problems: ______________________________

☐ Asthma: ______________________________

☐ Depression / Anxiety: ______________________________

☐ Kidney Disease: ______________________________

☐ Liver Disease: ______________________________

☐ Bowel Problems: ______________________________

☐ Epilepsy / Seizures: ______________________________

☐ Sleep Apnea: ______________________________

☐ Other: ____

☐ Other: ____

4. Personal Past Surgical History

Please indicate your past surgical history in the table below:

Date	Location / Surgeon	Type of Surgery

5. Current Medications and Allergy History

Please indicate your current usage of medications, vitamins, and supplements in the table below:

Medication / Vitamin / Supplement	Dose	Frequency

Do you have a reaction to Latex: ☐ Yes ☐ No

Please indicate your medication allergies and/or any other allergies in the table below:

Medication Allergies	Reaction

Other Allergies	Reaction

6. Family History

List the history for parents, grandparents (maternal and paternal), brothers and/or sisters, and children in the table below.

Check Yes or No	Condition	Age, Type, and Relationship to you
☐ **Yes** ☐ **No**	Breast Cancer	
☐ **Yes** ☐ **No**	Ovarian Cancer	
☐ **Yes** ☐ **No**	Colon Cancer	
☐ **Yes** ☐ **No**	Other Cancer	
☐ **Yes** ☐ **No**	Osteoporosis	
☐ **Yes** ☐ **No**	Heart Attack	
☐ **Yes** ☐ **No**	Stroke	
☐ **Yes** ☐ **No**	Blood Clots	
☐ **Yes** ☐ **No**	Reaction to Anesthesia	
☐ **Yes** ☐ **No**	Other (please specify):	
☐ **Yes** ☐ **No**	Other (please specify):	

Please indicate any inherited disorders or known genetic mutations: ____

Please list other serious medical problems in the family history: ____

☐ Please check here if your family history is unknown.

7. Social History

Please check the following applicable boxes and complete the information below:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ____

Occupation: ____

Exercise (frequency and type): ____

I **smoke** __________ pack(s) per day, and I quit _________________ months/years (circle one) ago.

I have __________ **beer/wine/drink**(s) per day / per week (circle one).

I have used "**street drugs**", please list type: ____

8. Obstetrical History

Please check the following applicable boxes and complete the information below:

Total number of pregnancies: ______________

Number of living children: ______________

Number of adopted/step-children: ______________

Number of miscarriages: ______________

Number of abortions: ______________

Date of Delivery	Location	Weight	Sex	Type of Delivery	Complications

END OF QUESTIONNAIRE

FOR OFFICE USE ONLY

Reviewed by: ____ Date: ________________________