

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

## James A. Simon, M.D., PC Patient Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

How did you hear about us? Friend Yelp Facebook Other Internet Source Physician Referral

Referred by: \_\_\_\_\_

Address of Referring Physician(s): \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_  
\_\_\_\_\_

Reason for today's appointment: (Please check the appropriate statements below)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Routine exam - no problems | <input type="checkbox"/> Second opinion        | <input type="checkbox"/> Overweight              |
| <input type="checkbox"/> Bleeding between periods   | <input type="checkbox"/> Irregular periods     | <input type="checkbox"/> Underweight             |
| <input type="checkbox"/> Stopped having periods     | <input type="checkbox"/> Light periods         | <input type="checkbox"/> Heavy periods           |
| <input type="checkbox"/> Never had periods          | <input type="checkbox"/> Menopause             | <input type="checkbox"/> Hormone therapy         |
| <input type="checkbox"/> Premenstrual discomfort    | <input type="checkbox"/> Pelvic pain or cramps | <input type="checkbox"/> Excess hair growth      |
| <input type="checkbox"/> Contraception              | <input type="checkbox"/> Cannot get pregnant   | <input type="checkbox"/> Reverse tubal operation |
| <input type="checkbox"/> Previous miscarriage(s)    | <input type="checkbox"/> Vaginal infection     | <input type="checkbox"/> Bladder infection       |
| <input type="checkbox"/> Breast problems            | <input type="checkbox"/> Bone density          | <input type="checkbox"/> Osteoporosis            |

Any other gynecologic problems or concerns you wish to address today: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following questions by filling in the blank or by checking "Yes" if it is the appropriate response.**

### Menstrual History

Age at first menstrual-period	_____	Do You Have:	<b>YES</b>
Starting date of last period	_____	Heavy bleeding	_____
Starting date of period before that one	_____	Bleeding between periods	_____
Usual # of days from start of one period to the next	_____	Pain with periods	_____
		Premenstrual symptoms (bloating, breast soreness,	_____

Bleeding lasts (# of days) \_\_\_\_\_ fatigue, irritability)  
Age at menopause, if applic. \_\_\_\_\_

### Gynecologic History

	<b>YES</b>
Date of last pelvic exam: _____	
Date of last pap smear: _____; was it abnormal?	_____
Have you ever had an abnormal pap smear	_____
Date of last mammogram: _____; was it abnormal?	_____
Do you have hair growth you consider abnormal?	_____
If yes, did you receive treatment?	_____
Do you have discharge from your breasts?	_____
Have you ever had a tubal infection?	_____
If yes, were you treated with antibiotics?	_____
History of venereal disease (gonorrhea, syphilis, herpes, chlamydia, etc.)? If so, specify _____	_____
Did your mother take diethylstilbestrol while pregnant with you?	_____

### Sexual History

Are you sexually active?	_____
Frequency of sexual intercourse per week _____	_____
Is intercourse painful?	_____
Have you ever been treated for the pain?	_____
If yes, describe _____	_____
Do you have any sexual questions or concerns you would like to discuss?	_____
_____	_____
_____	_____

### Contraceptive History

	<b>YES</b>
Are you using a form of birth control?	_____
If so, please list: _____	
Have you ever used:	
Birth control pills:	_____
Which types and dates used _____	
_____	
IUD (intrauterine device)	_____
Type _____ Dates used _____	
Problems (please list) _____	
Diaphragm	_____
Condom	_____
Other: _____	_____

## Obstetrical History

How many times have you been pregnant? \_\_\_\_\_

If applicable, please describe below:

Premature Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_ Living Children: \_\_\_\_\_

<u>Date</u>	<u>Weeks Preg</u>	(Check appropriate section)				<u>Complications</u>
		<u>Vaginal</u>	<u>C-sect</u>	<u>Miscar</u>	<u>Abort</u>	
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

## Surgical History

Please describe any previous pelvic or abdominal surgery (on the uterus, ovaries, tubes, cervix, or intestines including laparoscopies or appendectomy)

<u>Type of Surgery</u>	<u>Year</u>	<u>Reason or Diagnosis</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any other surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Medical History

Do you have a history of:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Emotional Problems  | <input type="checkbox"/> Ulcers or Stomach Problems | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gall Bladder Disease       | <input type="checkbox"/> Easy Bruising     |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Kidney Infections   | <input type="checkbox"/> Kidney Stones              | <input type="checkbox"/> Loss of Urine     |
| <input type="checkbox"/> Bowel Problems      | <input type="checkbox"/> Bladder Infections         | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Liver Problems      | <input type="checkbox"/> Hepatitis or Jaundice      | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Lung Disease               | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Chronic Cough       | <input type="checkbox"/> Sinus Problems             | <input type="checkbox"/> Seizure Disorders |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Difficulty Swallowing      | <input type="checkbox"/> Hearing Problems  |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Skin Problems, Acne        | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Anorexia, Bulimia   | <input type="checkbox"/> Other: _____               |  |

Please list treatments prescribed for items above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Family History

**YES**

- Indicate your ethnic background (i.e. African American, Mediterranean, Eastern European Jewish): \_\_\_\_\_
- Does anyone in your family have a genetic disorder (i.e., cystic fibrosis, sickle cell anemia, Tay-Sachs, thalassemia)? \_\_\_\_\_  
If so, how are they related to you?: \_\_\_\_\_
- Does anyone in your family have mental retardation? \_\_\_\_\_  
If so, how are they related to you?: \_\_\_\_\_
- Does anyone in your family have a birth defect (i.e., clubfoot, cleft lip and/or palate)? \_\_\_\_\_  
If so, how are they related to you?: \_\_\_\_\_
- Does anyone in your family have a chromosome abnormality (i.e. Down Syndrome, or Mongolism)? \_\_\_\_\_  
If so, how are they related to you?: \_\_\_\_\_
- Is there a family medical history of cancer? \_\_\_\_\_  
If so, what relative and what kind of cancer \_\_\_\_\_
- Is there a family medical history of diabetes? \_\_\_\_\_

Please list any other medical problems which seem to run in your family or are of concern to you:

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## Social History

**YES**

- Have you had previous marriages? If so, how many? \_\_\_\_\_
- Have you ever lived or traveled outside of the U.S.? \_\_\_\_\_  
If so, where? \_\_\_\_\_
- Do you smoke cigarettes now? If yes, how many packs/week? \_\_\_\_\_  
Have you smoked before and stopped? \_\_\_\_\_  
How many years have you smoked in total? \_\_\_\_\_
- Do you drink alcohol? If so, how many glasses/week? \_\_\_\_\_
- Do you use recreational drugs? \_\_\_\_\_  
If so, specify \_\_\_\_\_
- Have you ever worked with toxic chemicals, heavy metals or ionizing radiation? If so, specify \_\_\_\_\_
- How many hours do you exercise each week? \_\_\_\_\_
- Which sports you participate in: \_\_\_\_\_

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