

Medical Group

New Patient Intake Questionnaire

Name: _____

Names & Phone #'s for physicians involved in your care

Referring Physician	Other physician #1
_____	_____
#(p)	#(p)
_____	_____
#(f)	#(f)

In brief, what is the main reason you are seeing the doctor today:

What was the first day of your last menstrual period: _____

How many pregnancies have you had _____

How many living children do you presently have _____

List any allergies to medications _____

Please list below all other current medical conditions or previous surgeries

Medical Conditions	Surgeries (Date, Surgeon)
List all medical conditions	
Do you have the any of the following?	
Fibromyalgia	Yes No
Chronic Fatigue Syndrome	Yes No
Interstitial Cystitis	Yes No
Irritable Bowel Syndrome	Yes No
Low Back Pain	Yes No
Chronic Headaches	Yes No
TMJ (temporomandibular joint disorder)	Yes No

MEDICATIONS - current	FAMILY HISTORY
	Please indicate if any members have the following: (and list who they are – ex. maternal grandmother)
	Breast cancer
	Colon cancer
	Ovarian cancer
	Easy bleeding problems
	Blood clotting issues

REVIEW OF SYSTEMS: Please mark any symptoms that you have experienced in the last 3 months.

check this box if you do NOT have any of these symptoms

General	√ = yes	Gastrointestinal	√ = yes
Chronic fatigue		Nausea or vomiting	
Fevers		Poor appetite	
Difficulty falling or staying asleep		Abdominal bloating/fullness	
Unintentional weight loss		Heartburn	
Unintentional weight gain		Constipation	
Skin		Diarrhea	
Rash		Blood in stools	
Itching		Pain with bowel movements	
Vaginal / vulvar ulcers or fissures		Urinary	
Head and Neck		Frequent urination (>8 times/day)	
Itchy eyes		Urgency (sudden urge to urinate)	
Sore throat		Urine leaking	
Mouth sores or ulcers		Pain with urination	
Bleeding gums		Blood in urine	
Heart		Incomplete bladder emptying	
Chest pain		Night time urination (>2 /night)	
Irregular heart beat		Musculoskeletal	
Ankle/foot swelling		Muscle or joint pain	
Lungs		Body aches or stiffness	
Shortness of breath		Leg pain	
Chronic cough		Back pain	
Wheezing		Neurologic	
Endocrine		Headaches	
Excess hair growth		Dizziness	
Nipple discharge		Memory Loss	
Hot flashes		Low attention	

Some women experience pain during the following times or with certain activities. Please rate the severity of pain that you experience during these times by marking ONE box for each activity. Please answer all questions

“0” indicates no pain at all, “10” indicates pain as bad as you can imagine.

	0=no pain					10=pain as bad as you can imagine					
	0	1	2	3	4	5	6	7	8	9	10
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with full bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with entry during intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with tampon insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Go to the next page only if you are seeing the doctor for pelvic pain issues

PRIOR TREATMENTS for Pelvic Pain symptoms:

- Please mark ALL treatments that you have ever used FOR YOUR PELVIC PAIN,
 - LIST THE SPECIFIC MEDICATION UNDER HORMONAL THERAPY, ANTI-SEIZURE MEDICATION, ANTIDEPRESSANT MEDICATION, AND OPIOID MEDICATION
- Please mark the “NO” box if you have never used the listed treatment for pelvic pain.
- For each treatment that you have used, please indicate how long you used this medication for (in months)
- For each treatment that you have used, please indicate whether you are still using this medication for pelvic pain, and how helpful each treatment was (or has been) for your pelvic pain.

TREATMENT	YES	NO	Total duration of use (months)	CHECK BOX IF You are STILL USING THIS TREATMENT	HOW HELPFUL was this treatment? <i>Check one box</i>				
					NOT at all	A little bit	Some-what	A great deal	A very great deal
Hormonal therapy:		<input type="checkbox"/> I have not used hormonal therapy							
a.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-seizure medications		<input type="checkbox"/> I have not used anti-seizure medications for my pain							
a.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressant medications		<input type="checkbox"/> I have not used antidepressant medications for my pain							
a.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioid medications (ex: Vicodin, Percocet, Lortab, Oxycontin)		<input type="checkbox"/> I have not used opioid medications							
a.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.				<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any over-the-counter pain medicines (ex: Ibuprofen, Aleve, Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mirena IUD	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other medication:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nerve blocks or injections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EXAMPLES OF MEDICATIONS (these are just examples, you may have been on other medications):

HORMONAL THERAPIES:

Oral contraceptive pills Anastrazole (Arimidex)
 contraceptive patch Letrozole (Femara)
 contraceptive vaginal ring Danazol
 DepoProvera Oral progestin: provera, prometrium
 DepoLupron, Zoladex, Synare Norethindrone (aygestin)

ANTI-SEIZURE MEDICATIONS

Gabapentin (Neurontin)
 Pregabalin (Lyrica)
 Tigabine (Gabitril)
 Topiramate (Topamax)
 Lamotrigine (Lamictal)

ANTI-DEPRESSANTS

Amitriptyline (Elavil) Paroxetine (Paxil)
 Nortriptyline (Pamelor) Citalopram (Celexa)
 Desipramine (Norpramin) Sertraline (Zoloft)
 Imipramine (Tofranil) Venlafaxine (Effexor)
 Fluoxetine (Prozac) Duloxetine (Cymbalta)

