NorthShore
University HealthSystem

Dept. of Obstetrics and Gynecology
Division of Gynecological Pain and Minimally Invasive Surgery
Frank Tu, MD, MPH Sangeeta Senapati, MD, MS Howard Topel, MD

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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with full bladder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with bowel movements	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Deep pain with intercourse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with entry during intercourse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain with tampon insertion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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? *Check one box***				
					NOT at all	A little bit	Some-what	A great deal	A very great deal
Hormonal therapy:		☐ I have not used hormonal therapy							
a.				☐ →	☐	☐	☐	☐	☐
b.				☐ →	☐	☐	☐	☐	☐
c.				☐ →	☐	☐	☐	☐	☐
Anti-seizure medications		☐ I have not used anti-seizure medications for my pain							
a.				☐ →	☐	☐	☐	☐	☐
b.				☐ →	☐	☐	☐	☐	☐
Antidepressant medications		☐ I have not used antidepressant medications for my pain							
a.				☐ →	☐	☐	☐	☐	☐
b.				☐ →	☐	☐	☐	☐	☐
Opioid medications (ex: Vicodin, Percocet, Lortab, Oxycontin)		☐ I have not used opioid medications							
a.				☐ →	☐	☐	☐	☐	☐
b.				☐ →	☐	☐	☐	☐	☐
Any over-the-counter pain medicines (ex: Ibuprofen, Aleve, Tylenol)	☐	☐		☐ →	☐	☐	☐	☐	☐
Mirena IUD	☐	☐		☐ →	☐	☐	☐	☐	☐
Other medication: _____	☐	☐		☐ →	☐	☐	☐	☐	☐
Physical therapy	☐	☐		☐ →	☐	☐	☐	☐	☐
Acupuncture	☐	☐		☐ →	☐	☐	☐	☐	☐
Nerve blocks or injections	☐	☐		☐ →	☐	☐	☐	☐	☐

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

HORMONAL THERAPIES:		ANT-SEIZURE MEDICATIONS	ANTI-DEPRESSANTS	
Oral contraceptive pills	Anastrazole (Arimidex)	Gabapentin (Neurontin)	Amitriptyline (Elavil)	Paroxetine (Paxil)
contraceptive patch	Letrozole (Femara)	Pregabalin (Lyrica)	Nortriptyline (Pamelor)	Citalopram (Celexa)
contraceptive vaginal ring	Danazol	Tigabine (Gabitril)	Desipramine (Norpramin)	Sertraline (Zoloft)
DepoProvera	Oral progestin: provera, prometrium	Topiramate (Topamax)	Imipramine (Tofranil)	Venlafaxine (Effexor)
DepoLupron, Zoladex, Synare	Norethindrone (aygestin)	Lamotrigine (Lamictal)	Fluoxetine (Prozac)	Duloxetine (Cymbalta)