



## New Patient Questionnaire, Page 2

### Pregnancy History

Total Pregnancies # \_\_\_\_\_ Live Births # \_\_\_\_\_ Miscarriages # \_\_\_\_\_ Abortions # \_\_\_\_\_  
 Ectopic(tubal) pregnancies # \_\_\_\_\_ C-Sections # \_\_\_\_\_

Children's Birth Information:

	Birthdate	Wt	Sex	Complications		Birthdate	Wt	Sex	Complications
1					5				
2					6				
3					7				
4					8				

### Family History

Natural Mother:  Living, Age \_\_\_\_\_  Health Problems  Deceased, Age \_\_\_\_\_ Cause of Death \_\_\_\_\_  
 Natural Father:  Living, Age \_\_\_\_\_  Health Problems  Deceased, Age \_\_\_\_\_ Cause of Death \_\_\_\_\_  
 Siblings: \_\_\_\_\_  Health Problems \_\_\_\_\_  
 Children: \_\_\_\_\_  Health Problems \_\_\_\_\_

Has anyone had:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or stroke before age 50	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis, frequent fractures
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Who: _____ Part of body: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

### Social History

Marital Status:  Single  Married  Separated  Divorced  Widowed  Living w/ Partner  
 Education:  Grade  H.S.  Voc.  College  Advanced Degree  
 Language: \_\_\_\_\_ Religion: \_\_\_\_\_

### Employment Status

Working Occupation: \_\_\_\_\_  Retired  At Home/Child Care  Disabled  Unemployed

### Risk Factors

Tobacco: Age started: \_\_\_\_\_ Year Quit: \_\_\_\_\_  Never Passive smoke exposure:  current  past  
 Cigarettes: \_\_\_\_\_ pck/day  
 Alcohol: Type \_\_\_\_\_ # Drinks: \_\_\_\_\_ /day \_\_\_\_\_ /week \_\_\_\_\_ /month \_\_\_\_\_ /year  
 Drugs: Which recreational drug do you use?  None  Cocaine  Marijuana Other: \_\_\_\_\_  
 Caffeine:  Coffee  Tea  Cola Cups/day \_\_\_\_\_  
 Exercise: Type: \_\_\_\_\_ Times per week \_\_\_\_\_  
 Current Immunizations:  Tetanus  Flu  Pneumonia  Rubella  Hepatitis  Polio  
 Seatbelt use (%) \_\_\_\_\_  
 Examine your breasts:  Occasionally  Regularly

**SIGNATURE:** \_\_\_\_\_

## Review of Systems

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Problems you had in the past or are currently experiencing:

None

**Past      Present**

**General**

- Weight Loss
- Weight Gain
- Fevers
- Fatigue
- Sleep problems

**Breast**

- Pain
- Mass
- Nipple Discharge

**Kidney/Bladder**

- Painful urination
- Leakage / incontinence
- Frequency
- Urgency
- Blood in urine

**Cardiovascular**

- Chest pain or tightness
- Palpitations or heart racing
- Difficulty breathing
- Shortness of breath with exertion
- Hand / ankle swelling

**Respiratory**

- Wheezing
- Coughing
- Shortness of breath
- Coughing blood

**Gastrointestinal**

- Bleeding from the bowels
- Indigestion / heartburn
- Gas / bloating
- Diarrhea
- Constipation
- Hemorrhoids
- Difficulty controlling bowel movements
- Abdominal pain
- Nausea / vomiting

**Endocrine**

- Hot/Cold intolerance
- Hair loss
- Hot flashes

**Past      Present**

**Musculoskeletal**

- Muscle or Joint Pain
- Muscle weakness
- Fractures
- Loss of Height

**Skin Problems or Cancerous Growths**

- Skin Ulcers
- Moles
- Rashes

**Neurological**

- Headaches
- Numbness
- Seizures
- Trouble walking

**Mental Health**

- Depression
- Anxiety
- Forgetfulness
- Job problems
- Personal problems

**Eyes / Ears**

- Vision changes
- Wear glasses or contacts
- Hearing Loss
- Sinusitis

**Allergy**

- Persistent infections
- Hives
- Seasonal Allergies

**Blood**

- History of blood clots in legs or lungs
- Easily Bruised
- Excessive Bleeding

Signature \_\_\_\_\_

## Prenatal Questionnaire

Gynecological History		Infection History	
Have you ever had?		Have you ever had?	
<input type="checkbox"/> Y <input type="checkbox"/> N	Breast disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Chickenpox
<input type="checkbox"/> Y <input type="checkbox"/> N	An abnormal pap smear	<input type="checkbox"/> Y <input type="checkbox"/> N	Chickenpox vaccine
<input type="checkbox"/> Y <input type="checkbox"/> N	Infertility/Artificial Insemination Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N	Genital Herpes
<input type="checkbox"/> Y <input type="checkbox"/> N	DES exposure	<input type="checkbox"/> Y <input type="checkbox"/> N	A partner with a history of Genital Herpes
<input type="checkbox"/> Y <input type="checkbox"/> N	GYN disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	A STD (GC, Chlamydia, Syphilis, HIV)
Medical History		Risk Factors	
Have you ever had?		<input type="checkbox"/> Y <input type="checkbox"/> N	Do you currently smoke?
<input type="checkbox"/> Y <input type="checkbox"/> N	Disease in your Head, Eyes, Ears, Nose, or Throat	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever smoked in the past?
<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease		If yes, what year did you quit? _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you live with/work with someone who smokes?
<input type="checkbox"/> Y <input type="checkbox"/> N	Pre-Eclampsia	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you currently use alcoholic beverages?
<input type="checkbox"/> Y <input type="checkbox"/> N	Lung Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Prior to this pregnancy did you consume alcoholic beverages?
<input type="checkbox"/> Y <input type="checkbox"/> N	GI/Liver/Hepatitis Disease		If yes, how often did you drink alcoholic beverages? _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Gynecologic or Urinary Disorder		If yes, how many alcoholic beverages did you usually have per occasion? _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Frequent Urinary Tract Infections		
<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes		
<input type="checkbox"/> Y <input type="checkbox"/> N	Gestational Diabetes		
<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you currently use street drugs?
<input type="checkbox"/> Y <input type="checkbox"/> N	Neurological Disorders		If yes, what? _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have a history of alcohol or substance abuse?
<input type="checkbox"/> Y <input type="checkbox"/> N	Migraine		
<input type="checkbox"/> Y <input type="checkbox"/> N	Bleeding/Clotting Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever sought and/or received treatment for alcohol or drug problems? If yes, when? _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Disorder		
<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you used any medications since your last menstrual period? If yes, what medicine? _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Postpartum Depression		
<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Did you use Folic Acid prior to your pregnancy?
<input type="checkbox"/> Y <input type="checkbox"/> N	Musculoskeletal Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you been exposed to X-rays since you last menstrual period?
<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Disorders		
<input type="checkbox"/> Y <input type="checkbox"/> N	Transfusions		
		Infection Risk History	
<input type="checkbox"/> Y <input type="checkbox"/> N	Prior C-Sections	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you at a high risk for Hepatitis B infection?
<input type="checkbox"/> Y <input type="checkbox"/> N	Other Surgery: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you immunized against Hepatitis B?
<input type="checkbox"/> Y <input type="checkbox"/> N	Sexual Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	Have you been exposed to TB?
<input type="checkbox"/> Y <input type="checkbox"/> N	Domestic Violence		
		Environmental Exposures	
Has anyone in your family ever had?		<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had a rash, viral or febrile illness since your last menstrual period?
<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes		
<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have any occupational exposure to children? If yes, what is your occupation: _____
<input type="checkbox"/> Y <input type="checkbox"/> N	Multiple Gestation		
<input type="checkbox"/> Y <input type="checkbox"/> N	Other : _____	<input type="checkbox"/> Y <input type="checkbox"/> N	Do you have a history of Parvovirus (Fifth Disease)?
<i>For office use: Place patient label here</i>		<input type="checkbox"/> Y <input type="checkbox"/> N	Have you been exposed to any chemicals?
		<input type="checkbox"/> Y <input type="checkbox"/> N	Have you been exposed to cat litter since your last menstrual period?
		<input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever had other exposure you think we should be aware of? If yes, what kind?

## Prenatal Questionnaire

Patient's Family Genetic History		Father of Baby's Family Genetic History	
Do you have a family history of		Does the father of the baby have a family history of	
<input type="checkbox"/> Y <input type="checkbox"/> N	Thalassemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Thalassemia
<input type="checkbox"/> Y <input type="checkbox"/> N	Neural Tube Defect	<input type="checkbox"/> Y <input type="checkbox"/> N	Neural Tube Defect
<input type="checkbox"/> Y <input type="checkbox"/> N	Down Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N	Down Syndrome
<input type="checkbox"/> Y <input type="checkbox"/> N	Tay-Sachs	<input type="checkbox"/> Y <input type="checkbox"/> N	Tay-Sachs
<input type="checkbox"/> Y <input type="checkbox"/> N	Sickle Cell Disease/Trait	<input type="checkbox"/> Y <input type="checkbox"/> N	Sickle Cell Disease/Trait
<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia
<input type="checkbox"/> Y <input type="checkbox"/> N	Muscular Dystrophy	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscular Dystrophy
<input type="checkbox"/> Y <input type="checkbox"/> N	Cystic Fibrosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Cystic Fibrosis
<input type="checkbox"/> Y <input type="checkbox"/> N	Huntington's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Huntington's Disease
<input type="checkbox"/> Y <input type="checkbox"/> N	Mental Retardation	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental Retardation
<input type="checkbox"/> Y <input type="checkbox"/> N	Fragile X	<input type="checkbox"/> Y <input type="checkbox"/> N	Fragile X
<input type="checkbox"/> Y <input type="checkbox"/> N	Other Genetic/Chromosomal defects	<input type="checkbox"/> Y <input type="checkbox"/> N	Other Genetic/Chromosomal defects
<input type="checkbox"/> Y <input type="checkbox"/> N	Birth of child with other birth defects	<input type="checkbox"/> Y <input type="checkbox"/> N	Birth of child with other birth defects
<input type="checkbox"/> Y <input type="checkbox"/> N	Stillbirth	<input type="checkbox"/> Y <input type="checkbox"/> N	Stillbirth
<input type="checkbox"/> Y <input type="checkbox"/> N	Other (spina bifida, heart defect, blood disorder)	<input type="checkbox"/> Y <input type="checkbox"/> N	Other (spina bifida, heart defect, blood disorder)
Other questions			
<input type="checkbox"/> Y <input type="checkbox"/> N	Will you be 35 years or older when the baby is due?      Age when due: _____		
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you or the baby's father related to each other? (i.e. cousins)?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had three or more pregnancies that ended in miscarriage?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you delivered a premature baby?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you or the baby's father had a stillborn baby, a baby who died around the time of delivery, or a baby who was small for gestational age?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Where your ancestors came from may sometimes give us important information about the health of your baby. Are you or the baby's father from any of these ethnic/racial groups: Jewish, Black, Asian, Mediterranean (Greek, Italian)?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you or the baby's father ever been screened to see if either of you are carriers of the gene for any of the following: Tay-Sachs, Sickle Cell, Thalassemia, or Cystic Fibrosis?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you think you are at an increased risk of having a baby with a birth defect or genetic disorder? If yes, which defect or disorder? _____ Why do you think you are at an increased risk? _____		
<input type="checkbox"/> Y <input type="checkbox"/> N	At any time during the first two months of your pregnancy, have you had a rash or a fever of 103°F or greater?		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	Have you ever had a serious pelvic infection or pelvic inflammatory disease (PID)?		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	Do you think any of your male sexual partners have ever had sex with other men?		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	Have you or your sexual partners ever used IV street drugs?		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	Have you had sex with two or more partners in the last twelve months?		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	Do you think any of your sexual partners may have HIV or AIDS?		
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	Have you or your sexual partners ever had a blood transfusion?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you feel safe in your personal relationship?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you feel safe within your home?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Do you feel safe in your own neighborhood?		
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever had your feelings repeatedly hurt, been repeatedly put down, or experienced any other kinds of hurting?		
If you're under 18, and you answer yes to the following questions, your care provider must report this information to Child Protective Services.			
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you being or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt? If yes, by whom? <input type="checkbox"/> Husband <input type="checkbox"/> Family Member <input type="checkbox"/> Ex-Husband <input type="checkbox"/> Stranger <input type="checkbox"/> Partner <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> Y <input type="checkbox"/> N	Are you experiencing or have you ever experienced uncomfortable touching or forced sexual contact? If yes, by whom? <input type="checkbox"/> Husband <input type="checkbox"/> Family Member <input type="checkbox"/> Ex-Husband <input type="checkbox"/> Stranger <input type="checkbox"/> Partner <input type="checkbox"/> Other (specify) _____		
Patient Signature: _____		Date: _____	



**NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT**

SOUND  
WOMEN'S  
CARE

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Where would you prefer we contact you with **CONFIDENTIAL** information regarding your treatment or test results? Please leave at least one number where we could leave you a message.

Home Yes \_\_\_\_\_ Number: \_\_\_\_\_ **Voicemail okay?**  
Yes \_\_\_\_\_ No \_\_\_\_\_  
No \_\_\_\_\_

OR **Voicemail okay?**  
Work Yes \_\_\_\_\_ Number: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
No \_\_\_\_\_

OR **Voicemail okay?**  
Cell Yes \_\_\_\_\_ Number: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
No \_\_\_\_\_

I give permission for medical information about me to be shared with the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Signature of Patient)

**By my signature below, I acknowledge receipt of the Notice of Privacy Practices and give my permission regarding a confidential voice message as stated above.**

**I also hereby authorize my insurance benefits to be paid directly to Sound Women's Care, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers for payment of claims. I also authorize the release of information I request to be sent to insurance companies or employers (including disability forms).**

\_\_\_\_\_  
PRINT NAME Date of Birth

\_\_\_\_\_  
Patient or legally authorized individual signature Today's Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient Relationship  
representative) (parent, legal guardian, personal

This form will be retained in your medical record.

Last Update: 9-22-09