



New Patient Questionnaire

What is the reason for your visit?

What was the first day of your last period? _____

Were you referred by another doctor? If so please let us know which physician.

Have you ever been pregnant? Please list number of pregnancies: _____

Miscarriages: _____ Abortions: _____ Live Births: _____

Below please list if they were vaginal deliveries or C-sections followed by what year the children were born.

Please also include a list of any complications you may have had with the pregnancy.
(high blood pressure, diabetes, forceps or vacuum delivery)

When was your last pap smear? _____

Have you ever had an abnormal pap? If so, when? _____

If you have had an abnormal pap, have you ever had any of the following?
(please include the date)

COLPOSCOPY _____ LEEP _____ CRYO THERAPY _____

When was your last mammogram? _____

When was your last colonoscopy? _____

Why did you have one? _____

Have you ever had a bone density scan and if so, when? _____