CHICAGO
women's
HEALTH GROUP

New Patient Questionnaire

Name: _____ Date: _____

Please help us provide you the best healthcare by completing this short questionnaire.

What brings you to the office today? _____

Do you have any questions, problems, or concerns that you would like to discuss with us today?

_____

What are your gender pronouns?

- ☐ She, her, hers, herself
- ☐ He, him, his, himself
- ☐ They, them, theirs, themselves
- ☐ Ze, hir, hirs, hirself
- ☐ Just my name, please
- ☐ Other _____

What is your ethnicity/ancestry?

- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Black/African American
- ☐ French Canadian
- ☐ Hispanic/Latinx
- ☐ Mediterranean
- ☐ Native American or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Sephardic Jewish
- ☐ White/Caucasian
- ☐ Other _____

Obstetric & Gynecologic History

Date of your last menstrual period _____

How often do you have a period?_____

Do you have any concerns about your period?_____

Do you use a method of contraception? Yes No

If yes, please indicate which type _____

Do you use it regularly? Yes No

Are you/your partner satisfied with this method? Yes No

Do you want any information about birth control? Yes No

Are you sexually active? _____

Date of your last Pap smear _____

Do you have a history of abnormal Pap smears? Yes No

Did you receive the HPV / Gardasil® vaccine? Yes No

Date of your last mammogram _____

Have you had an abnormal mammogram? Yes No

Have you had a breast biopsy or surgery? Yes No

Have you ever been pregnant? Yes No

Do you have any of the following health problems?

Asthma	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid issues	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Postpartum depression	☐ Yes	☐ No

Other: _____

Have you ever had surgery? (If yes, please list.)

1. _____
2. _____
3. _____
4. _____
5. _____

What medications are you currently taking? (Please list each medication and your current dose.)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have allergies to any medications? Yes No

If yes, please list _____

Do you drink alcohol? Yes No

If yes, how many drinks per week? _____

Have you ever felt the need to cut down on drinking? Yes No

Do you smoke cigarettes or vape? Yes No

If yes, how many per day?_____

Do you use marijuana or recreational drugs? Yes No

If yes, please specify: _____

Are you exercising? Yes No

How often?_____

What type of exercise?_____

Do you have a family history of any of the following? (If yes, please list which family member)

Breast cancer	☐ Yes	☐ No	_____
Ovarian cancer	☐ Yes	☐ No	_____
Uterine cancer	☐ Yes	☐ No	_____
Colon cancer	☐ Yes	☐ No	_____
Pancreatic cancer	☐ Yes	☐ No	_____
Melanoma	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
High cholesterol	☐ Yes	☐ No	_____
Heart disease	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____
Thyroid disorders	☐ Yes	☐ No	_____
Bleeding disorders	☐ Yes	☐ No	_____
Blood clotting disorders	☐ Yes	☐ No	_____

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