Patient Intake Questionnaire **Dr. Shruthi Mahalingaiah**

Your Name: ____________________________ **Date:** __________________
Your Age: _______
What is the reason for your visit today? Infertility Recurrent Loss Fibroids PCOS/menstrual
Other: __________________

Name, Address & Phone # of Referring Provider: ____

____

Name, Address & Phone # of Primary Care Provider (if not at BMC): ______________________

____

Past Obstetric History
(List Pregnancies from first to last including miscarriages/abortions)

	Date	Please Circle Pregnancy Outcome	
1	___________	Miscarriage /Abortion/Ectopic/D&C/MTX	Vaginal/Cesarean/Preterm
2	___________	Miscarriage /Abortion/Ectopic/D&C/MTX	Vaginal/Cesarean/Preterm
3	___________	Miscarriage /Abortion/Ectopic/D&C/MTX	Vaginal/Cesarean/Preterm
4	___________	Miscarriage /Abortion/Ectopic/D&C/MTX	Vaginal/Cesarean/Preterm

Past Gynecology History
When did your last menstrual period start?___________ Age at first menstrual period __________
How often do you have menstrual period? ___________ # of days of menstrual flow_______________
Date of last pap smear:________________
Have you ever had abnormal pap smear? Yes No
Have you experienced any of the following?
Pelvic pain with period: Yes No Pelvic pain without periods: Yes No
Bleeding or Spotting between periods: Yes No
Do you currently use any form of birth control? Yes No
Have you ever had a pelvic infection? Yes No
How many times a month do you and your partner have sexual intercourse? __________
Do you or your partner have issues with sexual performance? Yes No
Do you use vaginal lubricants with intercourse? Yes No
Have you experienced: Acne Hot Flashes Changes in scalp or body hair Breast Discharge
Changes in body weight?

Do you have any Medical Problems or History? Please list:

Have you had any of the following medical problems?

Heart Disease:	Yes	No	Lung Condition or Asthma:	Yes	No	Cancer:	Yes	No
High Blood Pressure:	Yes	No	Liver Disease/Jaundice/ Hepatitis:	Yes	No	Kidney Disease:	Yes	No
Diabetes:	Yes	No	Stomach disorders/Gastritis/Ulcers:	Yes	No	Anemia:	Yes	No
Blood Clotting disorders:	Yes	No	Endocrine/ Thyroid Disease:	Yes	No	Bleeding Disorders:	Yes	No

Serious infections such as TB, rheumatic fever, HIV, Syphilis: Yes No Others: ____________________________

Past Surgical History: Reaction to Anesthesia Complications recovering

List date and type of surgeries you have gone through: ______________________________
____

List all medications you are currently taking with dosages, including vitamins & dietary/herbal supplements:
____
____

Are you allergic to:

Drugs: Yes No; If yes, name the drugs & your reaction: ______________________________

Latex: Yes No Iodine: Yes No Other Allergies: ______________________________

Social History

Marital Status______________ Occupation: ______________

Do you currently or have a history of: Smoking Alcohol Substance Abuse

If yes, how much do you smoke? ______________ If yes, how much do you drink on a weekly basis? ________

Ethnicity: White Hispanic African-American Asian Other:

Have you ever felt unsafe or threatened in a relationship? Yes No

Family Medical History

Mother(list age and medical problems): ______________________________

Father(list age and medical problems): ______________________________

# of Sisters:__________ #of children they have: __________

# of Brothers:__________ #of children they have: __________

Are there any genetic disorders in your partner's family ((Mental retardation, Down Syndrome, Cystic Fibrosis, other)?

Partner's History (if applicable)

Name:______________________ Age:______ Occupation:______________

How long have you been together?______________

# of pregnancies he conceived with other partners:______________

His/Her past medical history: ______________________________

His/Her past surgical history: ______________________________

His/Her medication (at present): ______________________________

Do he/she currently or has a history of: Smoking Alcohol Substance Abuse

If yes, how much does he/she smoke? __________

If yes, how much does he/she drink on a weekly basis? __________

Prior Evaluation

If you are trying to have a baby, when did you start trying? ______________________________

When did you first see a physician for reproductive issues?______________________________

Name & Address of Physician (s): ______________________________

If yes, what was done? ______________________________

Is there anything else you would like to share?