

Charles E. Miller, M.D & Associates
New Gynecology Patient Questionnaire

Name _____ Birthdate _____
Occupation _____
Height ____ ft ____ inches Weight ____ lbs.

Menstrual History

At what age was your first period? _____

On what date did your last period begin? _____

____ Yes ____ No

Are your periods regular?

If yes, how many days from the beginning of one period until the beginning of the next? _____

If no, how many periods in the past year? _____

List any medications that you have taken in the past year to help bring your period and how the medication was taken (i.e.daily, one week per month, etc.)

____ Yes ____ No

Do you have bleeding in-between periods?

____ Yes ____ No

Do you have painful periods?

Gyn History

____ Yes ____ No

Do you have pain during intercourse? If so, since when? _____

____ Yes ____ No

Do you have pain with bowel movements? If so, since when? _____

____ Yes ____ No

Do you have pelvic pain frequently?

If so, how often? _____

What circumstances can you identify that exacerbate the pain? _____

____ Yes ____ No

Do you have breast discharge?

____ Yes ____ No

Do you currently have acne?

____ Yes ____ No

Do you have an unusual amount of hair growth on your upper lip, chin, back or chest?

Yes No Have you ever had an abnormal PAP? Date of last PAP: _____

Yes No Have your tubes been tied?

List any pelvic infections as well as any sexually transmitted diseases you have had.

Pregnancy History

If none, state "none"

For outcome: EAB = Elective termination, SAB = Miscarraige (loss of pregnancy before 20 weeks),
ECT = Ectopic or Tubal Pregnancy, DEL = Delivery of baby or progression past 20 weeks

Year	Current Partner (Y/N)?	Months of trying	Outcome (see key above)	If ECT was tube removed (Y/N)?

Family History

Please check off any of the following that are or have been present in family members:

- | | | | |
|--------------------------------------------|---------------------------------------------|------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> > 3 miscarriages | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Genetic Disease | <input type="checkbox"/> TB | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Heart Disease |

Medical History

Please list any serious medical problems that you have. _____

Please list all medications that you are currently taking on a regular basis (either prescription or over the counter).

Medication	Purpose	Dosage

___ Yes ___ No Do you have any allergies (including to medications, iodine, latex)?
If yes, please list. _____

Surgical History

List any surgeries you have had (include dates and all procedures that were performed)

Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for your doctor to assess your score. Please do not mark anything in these columns. Be sure to bring this questionnaire with you into the examination room so that you can review your answers with your doctor.

Patient's name: _____ Today's date: _____

	0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1 How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2 a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3 Are you currently sexually active? YES _____ NO _____							
4 a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5 Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6 Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7 a. If you have pain, is it usually...		Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8 a. If you have urgency, is it usually...		Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
Please see full Prescribing Information on reverse.						SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) – SUBTOTAL	
						BOTHER SCORE (2b, 4b, 7b, 8b) – SUBTOTAL	
						TOTAL SCORE (Symptom Score + Bother Score) =	

ORTHO-McNEIL

ORTHO-McNEIL PHARMACEUTICAL, INC.
Raritan, New Jersey 08869-0602
©OMP 2003 02E9283 2/04

©2000 C. Lowell Parsons.