

Aguirre Specialty Care

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New Patient Questionnaire

IMPORTANT: Please complete this questionnaire carefully within 48 hours of making your appointment and return it by fax or mail to confirm your appointment.

Date of Visit: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____ Age: _____

CHIEF COMPLAINT

Please briefly describe the reason(s) that you are being seen in our office:

For how long have you experienced each problem?

Please list any previous tests or treatments for each condition:

PAST MEDICAL HISTORY

Have you ever had any of the following problems? Please circle Yes or No:

Explain:

Yes / No Bleeding problems (blood clots, anemia, past transfusions)

Yes / No Cancer

Yes / No Diabetes

Yes / No Eye disorder (glaucoma, chronic dryness)

Yes / No Neurological problems (seizures, migraines, stroke, fibromyalgia)

Yes / No Gastrointestinal disorders (ulcers, reflux,)

Yes / No Heart problems (irregular heart beat, murmur)

Yes / No Hernia

Yes / No High blood pressure

Yes / No Kidney problems (stones, infection, decreased function)

Yes / No Liver problems

Yes / No Musculoskeletal problems (osteoarthritis, loose joints)

Yes / No Psychiatric problems (depression, anxiety, bipolar disorder)

Yes / No Respiratory problems (asthma, COPD, emphysema, sleep apnea)

Yes / No Skin disorder

Yes / No Spine injury

Yes / No Thyroid disease

Yes / No Other:

REVIEW OF SYSTEMS

Check any conditions present today:

I have none of these problems today

Constitutional

- Recent weight change
- Fever
- Weakness
- Other _____

HEENT

- Visual problems
- Hearing problems
- Dry mouth
- Other _____

Cardiovascular

- Chest pain
- Varicose veins
- Blood clots
- Other _____

Respiratory

- Chronic cough
- Wheezing
- Oxygen use
- Other _____

Gastrointestinal

- Heartburn
- Nausea/Vomiting
- Hemorrhoids
- Other _____

Musculoskeletal

- Muscle pain
- Joint pain
- Limited mobility
- Other _____

Neurological

- Paralysis
- Numbness
- Tingling
- Other _____

Skin

- Rashes
- Sores
- Lumps
- Other _____

Endocrine

- Hot flashes
- Excessive thirst
- Other _____

Hematological

- Easy bruising
- Other _____

Immunologic

- Swollen lymph nodes
- Other _____

Psychiatric

- Depression
- Anxiety
- Other _____

OBSTETRICAL HISTORY

Skip this section. I have never been pregnant.

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____ Living Children: _____

<u>Date:</u>	<u>Weight:</u>	<u>Type of Delivery:</u>			<u>3rd / 4th Degree Tears:</u>
_____	_____	<input type="checkbox"/> vaginal	<input type="checkbox"/> vaginal with forceps/vacuum	<input type="checkbox"/> C-section	Yes / No
_____	_____	<input type="checkbox"/> vaginal	<input type="checkbox"/> vaginal with forceps/vacuum	<input type="checkbox"/> C-section	Yes / No
_____	_____	<input type="checkbox"/> vaginal	<input type="checkbox"/> vaginal with forceps/vacuum	<input type="checkbox"/> C-section	Yes / No
_____	_____	<input type="checkbox"/> vaginal	<input type="checkbox"/> vaginal with forceps/vacuum	<input type="checkbox"/> C-section	Yes / No
_____	_____	<input type="checkbox"/> vaginal	<input type="checkbox"/> vaginal with forceps/vacuum	<input type="checkbox"/> C-section	Yes / No
_____	_____	<input type="checkbox"/> vaginal	<input type="checkbox"/> vaginal with forceps/vacuum	<input type="checkbox"/> C-section	Yes / No

GYNECOLOGICAL HISTORY

Do you have menstrual periods? Yes No (skip to next question)

First day of last period: ____/____/____

Age at first period _____ Number of days between periods _____ Duration of bleeding: _____

Do you bleed between periods? Yes No

Do you have heavy periods? Yes No

Do you have a need for birth control? Yes No (skip to next question)

What method of birth control are you and your partner using? _____

Would you like to discuss a permanent method of birth control? No Yes

Have you gone through natural menopause? No Yes If yes, at what age? _____

Have you had a hysterectomy? No Yes

If yes, abdominal vaginal Reason for hysterectomy _____

Were your ovaries removed? No Yes If yes, which ovary(ies)? left right both

Date of last pap smear ____/____/____ Normal? Yes / No Have you ever had an abnormal pap? Yes / No

Date of last mammogram ____/____/____ Normal? Yes / No

Have you had a sexually transmitted disease? No Yes If yes, please list: _____

Name: _____ date: _____

SURGICAL HISTORY

Skip this section. I have never had any type of surgery.

List ALL surgeries with the date, if possible. Include abdominal and plastic surgeries

MEDICATIONS

Skip this section. I do not take any medications.

List all of the medications that you currently take, including over-the-counter medications and herbal supplements. List the dosage and how often you take it.

ALLERGIES

Skip this section. I have no known allergies.

List any allergies along with the type of reaction you experience.

SOCIAL HISTORY

Marital status: Single Married Divorced Separated Widowed
Living situation: Alone Family Skilled nursing facility/nursing home Other
Tobacco use: Yes No Daily amount _____ Number of years _____
Alcohol use: Yes No Daily amount _____
Street drug use: Yes No Type and daily amount _____
Caffeine use: Yes No Type and daily amount _____
Abuse: Yes No Describe _____
Exercise: Yes No Type and how often _____

FAMILY MEDICAL HISTORY

Please circle Yes or No:

Relationship:

Yes / No Bleeding disorder _____
Yes / No Cancer (list type) _____
Yes / No Diabetes _____
Yes / No Heart disease _____
Yes / No Hernia or vaginal prolapse _____
Yes / No Urinary problems _____
Yes / No Other: _____

Name: _____ date: _____

UROGYNECOLOGIC QUESTIONNAIRE

I urinate every _____ hours during the day.

At night, I get up _____ times to urinate.

Do you lose urine in spurts with laughing, sneezing, or exertion?.....	Yes	No
What amount of urine do you lose?.....	Small	Large Both
In what position do you lose urine?.....	Sitting	Standing Lying down
Do you lose urine with a strong sense of urgency?.....	Yes	No
Does the sound, sight, or feel of running water make you lose urine?.....	Yes	No
Do you lose urine without any warning (without activity or urgency)?.....	Yes	No
Do you wear a pad all of the time?.....	Yes	No
Is it difficult to get the urine stream started?.....	Yes	No
Does your urine stream seem slow or weak?.....	Yes	No
Do you feel that you empty your bladder completely when you urinate?	Yes	No
Do you have pain associated with urination?.....	Yes	No
Do you have frequent bladder infections?.....	Yes	No
Do you feel as if your pelvic organs are "falling down"?.....	Yes	No
Do you feel a bulge at the opening of your vagina?.....	Yes	No

BOWEL FUNCTION QUESTIONNAIRE

Skip this section. I have no problems with my bowel function.

I move my bowels _____ times per day or _____ times per week.

Do you have difficulty emptying your rectum?.....	Yes	No
What is the consistency of your stool when this happens?.....	Liquid	Soft Normal Hard
Does it help to press on the inside or outside of the vagina?.....	Yes	No
Do you lose control of stool?.....	Yes	No
What is the consistency of your stool when this happens?.....	Liquid	Soft Normal Hard
Do you have problems controlling gas?.....	Yes	No
Do you have alternating constipation and diarrhea?.....	Yes	No
Do you have pain with bowel movements?.....	Yes	No
Do you ever see blood in your stools?.....	Yes	No

COSMETIC GYNECOLOGY QUESTIONNAIRE

Skip this section. I have no problems with the appearance or function of my genital region

I am self-conscious about the appearance of my vulva/vagina.....	Yes	No
I am unhappy with the way my vagina looks (i.e. gaping).....	Yes	No
I am unhappy with the way my labia look (irregular, dark, long).....	Yes	No
My labia rub or pull on my clothing or during sex.....	Yes	No
I am unable to wear the type of clothing that I want.....	Yes	No
My vagina feels loose during sex.....	Yes	No
I have decreased sensation during sex.....	Yes	No
I wish to enhance my pleasure with sex.....	Yes	No
I want cosmetic vaginal surgery.....	Yes	No

SEXUAL FUNCTION QUESTIONNAIRE

Skip this section. I do not have any problems with my sexual functioning.

Sexual orientation: heterosexual homosexual bisexual

I have low desire to participate in sexual activity.....	Yes	No
I am unable to reach orgasm.....	Yes	No
I have significant difficulty reaching orgasm.....	Yes	No
I have a difficult time becoming aroused during sexual activity.....	Yes	No
I do not become sufficiently lubricated with sexual activity.....	Yes	No
I experience pain with vaginal penetration.....	Yes	No

Name: _____ date: _____

BODY CONTOURING QUESTIONNAIRE

Are you interested in Body Contouring?..... Yes No

I have tried exercise and diet, but can not get rid of the unwanted fat..... Yes No

I am unhappy with the appearance of my abdomen..... Yes No

I am unhappy with the appearance of my legs..... Yes No

I am unhappy with the appearance of my arms..... Yes No

I dislike the appearance of fat when wearing a bra..... Yes No

I am unhappy with the appearance of my pubic area/ labia majora Yes No

DERMAL AESTHETIC QUESTIONNAIRE

Do you have any concerns with the appearance of your skin?..... Yes No

Do you have any issues with Spider veins/varicose veins..... Yes No

Do you have any Anti aging skin care concerns..... Yes No

Do you want to learn more about Skin care products..... Yes No

Do you have any issues with wrinkles or fine lines..... Yes No

Do you have any issues with Sun spots/Age spots..... Yes No

Do you have any concern with Aging/dull looking skin..... Yes No

Do you have any issues with Large pores/Scars/Skin texture..... Yes No

Do you have any concern with Flushing of the skin/Redness..... Yes No

Do you have an interest in Laser Hair Removal..... Yes No

If Yes, what areas: _____

WEIGHT LOSS QUESTIONNAIRE

Are you interested in a weight loss option?Yes No

Have you tried any weight loss programs in the past?.....Yes No

If Yes, which ones have you tried? _____

For Office Use Only

Notes: _____

Name: _____ date: _____