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New Patient Questionnaire

IMPORTANT: Please complete this questionnaire carefully and return it to our office in order to schedule your appointment. Appointments cannot be scheduled without your completed paperwork.

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:	____________________

Name: ____ date:__________________________

REVIEW OF SYSTEMS

Check any conditions present today:

□ I have none of these problems today

Constitutional	HEENT	Cardiovascular	Respiratory
□ Recent weight change	□ Visual problems	□ Chest pain	□ Chronic cough
□ Fever	□ Hearing problems	□ Varicose veins	□ Wheezing
□ Weakness	□ Dry mouth	□ Blood clots	□ Oxygen use
□ Other________________	□ Other________________	□ Other________________	□ Other________________

Gastrointestinal	Musculoskeletal	Neurological	Skin
□ Heartburn	□ Muscle pain	□ Paralysis	□ Rashes
□ Nausea/Vomiting	□ Joint pain	□ Numbness	□ Sores
□ Hemorrhoids	□ Limited mobility	□ Tingling	□ Lumps
□ Other________________	□ Other________________	□ Other________________	□ Other________________

Endocrine	Hematological	Immunologic	Psychiatric
□ Hot flashes	□ Easy bruising	□ Swollen lymph nodes	□ Depression
□ Excessive thirst	□ Other________________	□ Other________________	□ Anxiety
□ Other________________			□ Other________________

OBSTETRICAL HISTORY

□ Skip this section. I have never been pregnant.

Number of pregnancies:__________ Miscarriages:_________ Abortions:__________ Living Children:_________

Date:	Weight:	Type of Delivery:			3rd / 4th Degree Tears:
____________	____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
____________	____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
____________	____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
____________	____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
____________	____________	□ vaginal	□ vaginal with forceps/vacuum	□ C-section	Yes / No
____________	____________	□ vaginal	□ vaginal with forceps/vacuum	□ 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

VAGINAL REJUVENATION 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:______________________

HORMONE QUESTIONNAIRE

□ Skip this section.

ESTROGENS

ESTROGEN DEFICIENCY

- ☐ Hot Flashes/ Heat from within
- ☐ I wake up at night sweating
- ☐ Dryness of vagina with sex/exercise
- ☐ My eyes are dry, irritated
- ☐ I can't think or remember
- ☐ Loss of urine
- ☐ Frequent urinary tract infections
- ☐ Bone loss (via bone density test)
- ☐ Frequently wakes up at night
- ☐ Heart palpitations'
- ☐ I'm so sad all the time
- ☐ Headaches
- ☐ My face is too hairy
- ☐ If menstruating; irregular cycles
- ☐ My breast are droopy

ESTROGEN EXCESS/ PROGESTERONE DEFICIENCY

- ☐ Large painful breast
- ☐ Ovarian Cysts
- ☐ Extreme mood swings
- ☐ My rings can't fit/ water retention
- ☐ I crave sugar/sweets
- ☐ Nervous/ anxious
- ☐ Heavy periods or changes in them
- ☐ I have/had breast cancer
- ☐ Sex? Who Cares?
- ☐ Fibrocystic breast disease
- ☐ Headaches; either with cycle or daily
- ☐ Irritability- not rational
- ☐ History of endometriosis
- ☐ History of endometrial hyperplasia or cancer
- ☐ Elevated triglycerides

THYROID

THYROID DEFICIENCY

- ☐ Sensitive to cold
- ☐ Constipation
- ☐ Fatigue/ Weakness
- ☐ Puts on weight easily
- ☐ I can't lose weight
- ☐ Unexplained aches/pains
- ☐ Muscle cramps
- ☐ I've lost my motivation
- ☐ Stressed out/ Irritable
- ☐ Hands and feet always cold
- ☐ Hair loss/ Weak nails
- ☐ Loss of outer 1/3 eyebrows

THYROID EXCESS

- ☐ Sensitive to heat
- ☐ Diarrhea/ Loose stools
- ☐ My heart races/ palpitations
- ☐ Unexplained weight loss
- ☐ Nervous/ anxious/ panic attacks
- ☐ Muscle weakness
- ☐ Coarse dry skin
- ☐ Tremors/Shakiness
- ☐ Can't slow down/ Insomnia
- ☐ My voice is hoarse/ breaks
- ☐ I sometimes feel pressure in my neck

ANDROGENS/ TESTOSTERONE

ANDROGEN DEFICIENCY

- ☐ I could care less about sex
- ☐ Loss of muscle tone
- ☐ Bone loss
- ☐ Thin skin/ More wrinkles
- ☐ Foggy Thinking/ Memory loss
- ☐ Aches, Pains
- ☐ Fibromyalgia

ANDROGEN EXCESS

- ☐ Where did all that facial hair come from?
- ☐ Increased body hair (nipples, umbilicus)
- ☐ Increased acne (jawline, forehead, back)
- ☐ My skin is more oily
- ☐ Irritability/ rage
- ☐ More Anxious

ADRENALS

CORTISOL DEFICIENCY

- ☐ I have allergies (seasonal, asthma….)
- ☐ Fast heartbeat/ palpitations
- ☐ Skin issues (eczema, psoriasis, uticaria, sensitive skin)
- ☐ Sugar/ Salt cravings
- ☐ I'm easily confused
- ☐ Digestive issues
- ☐ Low blood pressure
- ☐ Small things stress me out
- ☐ My face looks thinner
- ☐ I get cold easily
- ☐ Aches/ pains

CORTISOL EXCESS

- ☐ My muscles are weak/ wasted
- ☐ Poor wound healing
- ☐ I bruise easily
- ☐ My face is rounded/ "moon like"
- ☐ My skin is thinning
- ☐ Mood swings/ irritable
- ☐ My hands/ feet are puffy
- ☐ Increased body/ facial hair
- ☐ Menstrual irregularities/ no menses
- ☐ High blood pressure
- ☐ I get sick all the time
- ☐ My blood sugars are abnormal

Name: ______________________________ Date: ____________________

BODY CONTOURING QUESTIONNAIRE

Are you interested in Body Contouring?.. Yes No

Height_________ Current Weight___________ Goal Weight__________

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
I am unhappy with the appearance of my breasts……………………………. Yes No
I am unhappy with the appearance of my back & waist……………………….. Yes No

COOLSCULPTING CAN TARGET STUBBORN FAT IN THE AREAS THAT BOTHER YOU THE MOST.

Indicate below which problem areas would you be interested in transforming: (check all that apply)

☐ Under The Chin
☐ Bra Fat
☐ Abdomen
☐ Thigh (inner)
☐ Upper Arm
☐ Back Fat
☐ Flank/Side
☐ Underneath The Buttock (Banana Roll)
☐ Thigh (outer)

Name: ______________________________________ Date:____________________
Signature Date

For Office Use Only

Notes: ____

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