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*Obstetrics and Gynecology*

**Patient Questionnaire**

**Patient**

Name		Date
<hr/>		
Address	City, State, Zip	
<hr/>		
Phone Numbers: Home	Work	Cell
<hr/>		
Date of Birth	SS #	Drivers License #
<hr/>		
Marital Status: Single ___ Married ___ Divorced ___ Widow ___		Occupation _____
<hr/>		
Employer / School	Address	
<hr/>		
Who referred you to our office?	Insurance Co.	Friend / Relative
		Physician
		Other
<hr/>		
Person to notify in case of an emergency.	Name	Relation
		Phone#
<hr/>		

**Spouse / Parent / Guardian**

Name	Date of Birth	SS#
<hr/>		
Employer / School	Phone #	Address
<hr/>		

**Insurance Information**

**Primary Insurance**

Policy Holder's Name	Date of Birth	SS#
<hr/>		
Ins Co.	Patient's Relationship to Policyholder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____
<hr/>		
Claims Address	City, State, Zip	
<hr/>		
Group Number	Policy/ID Number	
<hr/>		
<b>Secondary Insurance</b>		
Policy Holder's Name	Date of Birth	SS#
<hr/>		
Ins Co.	Patient's Relationship to Policyholder	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____
<hr/>		
Claims Address	City, State, Zip	
<hr/>		
Group Number	Policy/ID Number	
<hr/>		

Date \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Reason for today's visit: Annual Exam \_\_\_\_\_ Other: \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_ Are your periods regular? \_\_\_\_\_ Any problems with your periods? \_\_\_\_\_

Present type of birth control? \_\_\_\_\_ Do you want to change birth control? \_\_\_\_\_ To what? \_\_\_\_\_

List all current medications: \_\_\_\_\_

\_\_\_\_\_

List all allergies to medications: \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, estimated number of drinks, beers, glasses of wine per week? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Have you ever used any other illicit drugs? \_\_\_\_\_ Type: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Any discomfort or difficulties? \_\_\_\_\_

Race / Ethnicity: \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_ Results \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_ Results \_\_\_\_\_

Date of last Bone Density \_\_\_\_\_ Results \_\_\_\_\_

Date of last Colonoscopy \_\_\_\_\_ Results \_\_\_\_\_

**Will you permit a blood transfusion for medical reasons?** \_\_\_\_\_

Pharmacy Name & Phone # \_\_\_\_\_

Do you need 1 month or 90 day prescription? \_\_\_\_\_

**List all surgeries:**

Type of surgery	Approximate Date	Type of surgery	Approximate Date
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

**Number of:** Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Living Children \_\_\_\_\_

Please list pregnancies in chronological order (including miscarriages and abortions):

Date	Sex	Wt.	Delivery Method	Complications
_____	_____	_____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	_____
_____	_____	_____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	_____
_____	_____	_____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	_____
_____	_____	_____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	_____
_____	_____	_____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	_____
_____	_____	_____	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	_____

Date \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

**Please indicate if the patient or a family member has a history of the following conditions:**

	Patient		Family Member		
Breast Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Fibrocystic Changes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Chlamydia / Gonorrhea / Syphilis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Genital warts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Herpes Infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Infection of the Tubes or Ovaries	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Abnormal Pap	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Tubal (Ectopic) Pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Tumor of the Uterus or Ovaries	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Anxiety	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Schizophrenia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Seizure Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Coronary Artery Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Heart Murmur	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Mitral Valve Prolapse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Cancer of the Colon/Rectum	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Irritable Bowel Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Crohn's Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Ulcerative Colitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Recurrent Urinary Tract Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Kidney Stones	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Skin Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Diabetes Mellitus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Hyperthyroidism	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Hypothyroidism	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Lymphoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Leukemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Osteoporosis or Osteopenia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Immunologic Lupus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Sickle Cell	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Tay-Sachs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Thalassemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?

Any other Health Conditions or Concerns: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_