Physician: Jon Ivar Einarsson MD MPH

NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire and bring it with you to your first visit

Date of Visit_____ Name_____

Date of Birth_____ Age_____

Cell phone # _____ Work phone # _____ Home phone # _____

Address: _____ City _____ State _____ Zip _____

BWH Reg # (number on blue card) _____ Insurance: _____

Referring Provider's Name and Address_____

_____

Primary Care Provider's Name and Address (if different from above)_____

_____

What are the **reasons** for your visit to the BWH Division of Minimally Invasive Gynecologic Surgery? (Mark all that apply)

Uterine fibroids	Pelvic pain
Ovarian cyst	Pain with intercourse
Abnormal uterine bleeding	Pelvic organ prolapse

Other: _____

Please elaborate on the reason for your visit here:

How long have you had the symptoms? _____ months _____years Are they getting worse? Yes No

If you have pain, how would you rate it on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain ever? _____

Does anything make your symptoms better? _____

Does anything make your symptoms worse? _____

What treatment (if any) have you received for your symptoms so far? No treatment Surgery Medications

Please describe your prior treatments here _____

_____

Past Gynecological History:

History of gynecologic problems (mark all that you have ever had):

Yeast infections	Trichomonas	Pelvic inflammatory disease (PID)
Bacterial vaginosis	Syphilis	HPV (human papilloma virus, genital warts)
Chlamydia	Frequent urinary tract infections	Cervical dysplasia (abnormal pap smear)
Herpes	Chronic vaginal discharge	AIDS/ HIV
Gonorrhea	Hepatitis B or C	

Date of last pap smear: _____ Results: Normal Abnormal_____

Date of last mammogram: _____ Results: Normal Abnormal_____

Were you exposed to DES in utero? Yes No Uncertain

Contraception: Please mark all boxes that apply I have never used contraception

METHOD	Current use	Used in the past	Duration of use (years)
Birth control pills/patch/ring			
Hormonal IUD			
Copper IUD			
Condoms			
Rhythm method			
Other:			

Menstrual History:

Do you have menstrual periods? Yes No

If you do NOT have menstrual periods, please indicate the reason:

menopause (age of menopause: _____ years old)
surgical removal of both ovaries
surgical removal of the uterus
hormonal medication, please specify: _____
other _____

When did your last menstrual period start?_____ Age at first menstrual period_____
How many days are in between your menstrual periods? _____ Are your periods regular? yes no
Days of menstrual flow_____

Which medications do you use for pain/cramps with your periods? How often?

None			
Tylenol	Never	Sometimes	Always
Ibuprofen, Aleve, Naprosyn	Never	Sometimes	Always
Prescription pain meds (ex: Vicodin, Darvocet, Percocet)	Never	Sometimes	Always
Other_____	Never	Sometimes	Always

Pelvic symptoms

Have you experienced any of these symptoms **during the last 6 months**?	Not at all	A little bit	Somewhat	A great deal	A very great deal
Heavy bleeding during your menstrual periods					
Cramping or pain during your menstrual period					
Irregular menstrual periods					
Bleeding or spotting in between your menstrual periods					
Pelvic pain on days other than during your menstrual period					
Pelvic pressure or fullness					
Pain with intercourse					

Have you been diagnosed with endometriosis/pelvic pain? yes no

If yes, please complete the following 5 questions (if you do not have pelvic pain, skip to next question)

During the last 4 weeks, how often because of your endometriosis have you…	Never	Rarely	Sometimes	Often	Always
Found it difficult to walk because of pain					
Felt as though your symptoms are ruling your life?					
Had mood swings?					
Felt others don't understand what you are going through?					
Felt your appearance has been affected?					

Plans for future pregnancies	Yes	No	Uncertain
Do you plan to become pregnant in the future?			
Is it important to maintain your option of getting pregnant?			
Have you had unprotected intercourse for > 12 months without getting pregnant?			
Have you had any treatment for infertility?			

If you have had treatment for infertility, please specify: _____

Have you leaked urine (even a small amount) in the last 3 months? Yes No (if no skip to next question)

During the last 3 months, did you leak urine most often: (choose one option)

When you were performing some physical activity such as coughing, sneezing, lifting or exercise?

When you had the urge or feeling that you needed to empty your bladder?

Without physical activity or a sense of urgency?

About equally as often with physical activity as with a sense of urgency?

In the last three months have you felt something was falling out of your vagina or that something was pushed out during coughing or straining? Yes No

If yes, please describe your symptoms in more detail here:

_____

_____

Risk of Nausea or vomiting (N/V) after surgery is affected by three historical risk factors (**please check the appropriate box**):

Prior history of travel sickness Prior history of N/V after anesthesia and If you do NOT smoke

Number of historical risk factors you have	Your risk of having nausea or vomiting after surgery
0	20-40%
1 or 2	40-80%
3	More than 80%

Pregnancies:

Please fill in the following table and use the code letters to indicate the outcome of each pregnancy.

Vag = Vaginal delivery Forc= Forceps delivery AB = Abortion

C/S = Cesarean section Vacu= Vacuum delivery Mis = Miscarriage

Year	Code	Weight of baby	Episiotomy or tear (√ = yes)		Year	Code	Weight of baby	Episiotomy or tear (√ = yes)
1.					5.			
2.					6.			
3.					7.			
4.					8.			

List additional pregnancies here

_____

_____

_____

Past and current medical history:

Please indicate if you have had or have any of these medical problems

I have no medical problems

Medical problem	√ = yes	Medical problem	√ = yes
High blood pressure		Ulcerative colitis	
Angina or chest pain		Crohn's disease	
Irregular heart beat or palpitations		Irritable bowel syndrome	
Heart attack or coronary artery disease		Chronic constipation	
Asthma		Chronic diarrhea	
Pulmonary embolus (blood clot in lungs)		Stomach ulcer	
Chronic headaches/migraine		Reflux (heart burn)	
Thyroid disease, specify:		Interstitial cystitis	
Kidney disease, specify:		Fibromyalgia	
Liver disease, specify:		Chronic low back pain	
Cancer, specify:		Diabetes	
Blood clot in legs or arms (DVT)		Breast disease, specify:	
Other:		Urinary tract infections	
Other:		Arthritis	

Have you ever been diagnosed or treated for any of these mental health conditions?

I do not have any of these conditions

Condition	Yes	No	Month, Year of diagnosis	Treatment:			Duration of treatment
				Medication	Counseling	Hospitalization	
Depression							
Anxiety							
Bipolar disorder							
Schizophrenia							

Previous surgeries:

List all previous surgeries along with their dates (include cesarean sections, tonsillectomies, appendectomies etc)

I have never had any surgery

Surgery	**Date**	**Laparoscopy or Hysteroscopy (minimally invasive surgery)**	**Laparotomy (large abdominal incision)**

Review of symptoms:

Please mark any symptoms that you have experienced in the last 3 months (√ = yes)

General	**(√ = yes)**	**Gastrointestinal**	**(√ = yes)**
Chronic fatigue		Nausea or vomiting	
Fevers		Poor appetite	
Difficulty falling or staying asleep		Abdominal bloating/fullness	
Unintentional weight loss		Heartburn	
Unintentional weight gain		Constipation	
Skin	**(√ = yes)**	Diarrhea	
Rash		Blood in stools	
Itching		Pain with bowel movements	
Vaginal or vulvar ulcers or fissures		**Urinary**	**(√ = yes)**
Head and neck	**(√ = yes)**	Urinary frequency	
Itchy eyes		Urgency (sudden urge to urinate)	
Sore throat		Urine leaking	
Mouth sores or ulcers		Pain with urination	
Bleeding gums		Blood in urine	
Heart	**(√ = yes)**	Incomplete bladder emptying	
Chest pain		Night time urination (>2/night)	
Irregular heart beat		**Musculoskeletal**	**(√ = yes)**
Ankle/foot swelling		Muscle or joint pain	
Lungs	**(√ = yes)**	Body aches and stiffness	
Shortness of breath		Leg pain	
Chronic cough		Back pain	
Wheezing		**Endocrine**	**(√ = yes)**
Neurologic	**(√ = yes)**	Excess hair growth	
Headaches		Nipple discharge	
Dizziness		Hot flashes	
Memory loss		Night sweats	
Low attention/difficulty concentrating		Changes in voice	

Current medications:

Please list all medications you currently take. Include any over-the-counter and herbal medicine you take:

Medication	Dose	How many times per day?

Allergies to medications:

List all medications that you are ALLERGIC to and your reaction to this medication:

Medication	Reaction (example: rash, difficulty breathing)

Social History:

Health habits

Do you…?	Yes	No	No, but did in the past	Quit date	If YES:
Smoke cigarettes					Packs per day: Years:
Drink alcohol					Drinks per week: Years:
Exercise					Hours per week:

Background information:

Race	____ 1. American Indian or Alaskan native ____ 2. Asian ____ 3. Native Hawaiian or Pacific Islander ____ 4. Black or African American ____ 5. White ____ 6. Middle Eastern ____ 7. More than one race	Education	____ 1. Grade school ____ 2. Completed High school ____ 3. Some College ____ 4. Associate Degree ____ 5. College/Bachelor's degree ____ 6. Post-graduate degree
Ethnicity	____ 1. Hispanic or Latino ____ 2. NOT Hispanic or Latino	Occupation	____ 1. Work outside home ____ 2. Homemaker ____ 3. Retired ____ 4. Disabled
Marital status	____ 1. Single ____ 2. Married ____ 3. Domestic partner ____ 4. Separated ____ 5. Divorced ____ 6. Widowed	Household income	____ 1. 0-10,000/year ____ 2. 10-30,000/year ____ 3. 30-50,000/year ____ 4. 50-100,000/year ____ 5. above 100,000/year

If you work outside the home, what is your occupation? _____
Have you ever felt unsafe or threatened in a relationship?_____
How long have you been with your present partner?_____

Family History:

Please list any close relatives with medical problems such as cancer, heart disease, fibroids etc

Family member	Medical problem (also list age)		Family member	Medical problem (also list age)
1.			**8.**	
2.			**9.**	
3.			**10.**	
4.			**11.**	
5.			**12.**	
6.			**13.**	
7.			**14.**	

Diagnostic testing:

Please list any diagnostic testing performed (and results, if available):

Diagnostic test	Date	Location	Results
FSH			
TSH			
Estradiol			
Prolactin			
Progesterone			
Endometrial biopsy			
Hysterosalpingogram			
Office hysteroscopy			
CT scan			
MRI			
Ultrasound			
Other:			
Other:			

If you have additional comments please write them here:

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. This will make your visit more efficient and allow more time for discussion of your current situation.