Women's Health associates

803.648.0803
121 Aurora Place, Suite A
Aiken, SC 29801

Name: ______________________________ Date: __________________

Date of birth: _______________________

## NEW PATIENT QUESTIONNAIRE

Current marital status: **S** **M** **W** **D** **Sep**

Occupation: ______________________________________________

Do you smoke? **Y** or **N** If so, how much? ____________________________________________

Do you drink alcohol? **Y** or **N** If so, how much? ____________________________________________

What do you do for exercise ____________________________________________

Who is your primary care doctor? ____________________________________________

When was the last time you had the following testing:

Cholesterol: ___________________ Bone density: ___________________ Pap: ___________________

Mammogram: ___________________ Colonoscopy: ___________________

Are you having periods? **Y** or **N** If so, when did the last one start? _______________________________________

Are you menopausal (stopped having periods)? **Y** or **N**

If so, what age did you stop having periods? ____________________________________________

List your drug allergies: ____________________________________________________________________________________

List your current medications: (list on back if more space is required)

___________________ ___________________ ___________________ ___________________ ___________________

Please list your **family** medical history:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Please list your **personal** medical history:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Please list any surgeries you have had:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

How many pregnancies have you had? ____________

# c-sections ___________ # normal vaginal deliveries ___________ # miscarriages ___________

# stillbirths ___________ # abortions ___________

## FOR MEDICARE PATIENTS ONLY

Medicare will pay for a pap smear every other year. It is recommended of this office that you have yearly pap smears; however, we understand that financially it may not be feasible. The cost is $78 if Medicare does not pay for it, and if Medicare does not pay, your secondary will not pay. Please choose ONE of the following:

_______ **I DO NOT** want my pap smear done this year if it was done last year.

_______ **I DO** want my pap smear done this year.

(Please note that we will file all charges to Medicare and secondary insurances before billing you. )