Dr. Alexander Klein

Gynecology, Infertility, Pelvic Reconstructive Surgery, Urogynecology, Menopause Management

New Patient Questionnaire

Name	Age	Race	Date
Home/work phone	Emergency Contact name/phone		
Primary Care Physician			
List all Medical Conditions/Problems,	past and pre	sent:	
1.		5.	
2.		6.	
3.		7.	
4.		8.	
List all Surgeries (include year):		List other	Hospitalizations (include year):
1.		1.	
2.		2.	
3.		3.	
4.		4.	
Current Medications and dosages		List Medic	ation Allergies (include reaction type)
(Including herbs, vitamins, and over-th	ne-counter)		
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
OB/GYN History:			
Age at onset of menses	First day of last menses		
Are your menses regular?	Days between last day and first day of menses		
Total days of bleeding per cycle	Number of heavy days		
Are your menses painful?	Is intercourse painful?		
Current contraception		Previous contrace	eption
If post-menopausal, age of last menses			
Have you ever had a sexually transmitte	ed disease su	uch as Chlamydia,	gonorrhea, syphilis, genital warts,
herpes, HIV, or hepatitis B or C?			
Number of: Pregnancies	Abortic	ons	C-sections
Miscarriages	Vaginal	l Deliveries	
Names and Ages of Children:			
1.		4.	
2.		5.	

3.