Thank you for trusting LUNA OBGYN with your care. We are pleased to welcome you as our patient. Please take a few moments to complete the questionnaire below, so that we may learn more about you before your visit. We look forward to caring for you at LUNA OBGYN

Patient Name: ____

Date of Birth:____

REASON FOR YOUR VISIT TODAY:

____

Have you been a patient of Dr. Faro or Dr. Wainwright before? (check box) Y ☐ or N ☐

If yes, please specify which provider you have seen before: ______________________

If no, please specify how you heard about Luna Obgyn, including referrals:

____

AUTHORIZATION: Do you agree or object to sharing information with a family member? agree ☐ object ☐

(this includes sharing medical records, appointments, lab results, billing, and medications)

Name: ______________________________ Relationship: ______________________

ALLERGIES & MEDICATIONS

Do you have any allergies to medications? Y ☐ or N ☐

If **Y**, please list medication and reaction:

____

Medications you are currently taking (please include prescribed, over the counter and supplements):

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

GYNECOLOGICAL HISTORY

When was your most recent:

Pap Smear ______________ (year) Normal ☐ Abnormal ☐ (check box)

Mammogram ______________ (year) Normal ☐ Abnormal ☐ (check box)

Bone Density ______________ (year) Normal ☐ Abnormal ☐ (check box)

Colonoscopy ______________ (year) Normal ☐ Abnormal ☐ (check box)

How old were you when you had your first period? __________ If applicable, year of your last period: ____________

Date of Last Menstrual Period: ______________

How frequently do your periods come? Every ________ days

How many days does your period last? _____________

Are your periods heavy? (check box) Y ☐ or N ☐

If Y, how many pads/tampons do you use per day: ___________

Do you experience cramping or pain with your periods? (check box) Y ☐ or N ☐

Have you ever been diagnosed with Fibroids: Y ☐ or N ☐ Ovarian Cysts? Y ☐ or N ☐

Have you ever had an abnormal Pap smear result? Y ☐ or N ☐ If yes, year of diagnosis: __________

If treatment is required, please check: ☐Cryotherapy (freezing) ☐Laser ☐Cone Biopsy ☐LEEP ☐Colposcopy

Have you ever had infections of the reproductive tract or any sexually transmitted infections (STIs)?

(check box) Y ☐ or N ☐ If Y, please check positive infections:

☐HPV ☐Chlamydia ☐Gonorrhea ☐ Trichomonas ☐Herpes (HSV) ☐HIV ☐Syphilis ☐Hepatitis

☐PID

Are you sexually active? Y ☐ or N ☐

If Y, your current partner(s) is/are: ☐Male ☐Female ☐Both (check one)

Do you have pain with intercourse? Y ☐ or N ☐

Are you trying to conceive? Y ☐ or N ☐

Current birth control method ____

Do you have any current vaginal discharge? Y ☐ or N ☐

Do you have any current breast issues/symptoms (lump, discharge, etc.?) Y ☐ or N ☐ If yes, please specify:

____

Have you ever had any abnormal mammograms or breast surgeries? Y ☐ or N ☐ If yes, please specify:

____

Do you have any problems with urinary incontinence (leakage of urine)? Y ☐ or N ☐

OBSTETRICAL HISTORY

Have you ever been pregnant? Y ☐ or N ☐
If Y, please indicate the total number of:

Full-Term Deliveries ______ Preterm Deliveries ______ Miscarriages ______
Terminations ______ Ectopic _______

Of those, how many deliveries were: Vaginal ______ C-Section ________

How many living children do you have? ________

PLEASE LIST ANY PREGNANCY COMPLICATIONS YOU EXPERIENCED:

____

Have you ever had infertility treatment? Y ☐ or N ☐ If Y, please describe:

____

MEDICAL & SURGICAL HISTORY

Do you have any medical conditions? Y ☐ or N ☐
If Y, please list:

____

____

Have you ever had any surgeries (including cesarean sections, breast biopsies, or D&C)? Y ☐ or N ☐
If Y, please list:

____

____

FAMILY HISTORY

Please indicate if any of your family members have/had the following: **M** (mother), **F** (father), **MGM/MGF** (Maternal grandmother/father) **PGM/PGF** (paternal grandmother/father) **B** (brother), **S** (sister), **MA/PA** (maternal/paternal aunts)

High Blood Pressure ______________________ Diabetes ________________________
High Cholesterol ______________________ Autoimmune Disease _______________
Colon Cancer ______________________ Breast Cancer _____________________
Uterine Cancer ______________________ Ovarian Cancer ___________________
Thyroid Disorder ______________________ Other Medical Problems ____________

IMMUNIZATION HISTORY

Have you received the COVID-19 Vaccine? Y ☐ or N ☐

If Y, manufacturer: ☐Pfizer ☐ Moderna ☐J&J Date Completed: ________________________

Have you received the Tdap Vaccine? Y ☐ or N ☐ Date: ______________

Have you received the Gardasil series? Y ☐ or N ☐ Date: ______________

Have you received the flu vaccine during the current season? Y ☐ or N ☐

If N, would you like the Flu Shot? Y ☐ or N ☐

Have you received the Measles, Mumps & Rubella vaccine? Y ☐ or N ☐ If Y, when? ________

50 years or older, have you received the shingles vaccine? Y ☐ or N ☐ If Y, when? ________

60 years or older, have you received the pneumonia vaccine? Y ☐ or N ☐ If Y, when? _______

SOCIAL HISTORY

Marital Status (circle one): ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner

Exercise Level (check one): ☐None (no exercise) ☐Occasional (1x/week)

☐Moderate (2-3x/week) ☐High (45x/week)

Caffeine Intake (check one): ☐None ☐Occasional ☐Moderate ☐Heavy # of cups/cans per day: _________

Tobacco Use (check one): ☐None ☐Previously Used ☐Currently Using

If you are currently using tobacco, what form are you using? (Check one) ☐Cigarettes ☐Chew

☐Cigars ☐ Vaping # of years using: _________

If you previously used Tobacco, year quit? __________

Have you ever used illegal drugs? Y ☐ or N ☐ If yes, what kind? ____________________________

Alcohol Intake (circle one): ☐None ☐Occasional ☐Moderate ☐Heavy # of drinks per week: ___________