SIGNATURE OB/GYN

Gynecology Questionnaire

WEIGHT ______ HEIGHT ______

Name:____ Date:_______________ Date of Birth:*_______________

Age: _______________ Race: _______________ Ethnicity:* _______________ Primary Language:* _________________
Preferred Pharmacy: ________________________ Location: __________________________ Phone#:________________
Required by Healthcare/Meaningful Use Legislation. Fax#:________________

Cell Phone: ______________________ Home Phone: ______________________ Work Phone: ______________________

If English is not your primary language, do you need a translator? (please circle) YES NO

Well Woman Update: (Please provide dates where applicable) Primary Care Provider (Doctor):____________________

Last bone density exam____________(year)
Last colonoscopy_________________(year)
Last mammogram________________(year)
Last Pap smear_____________(month/year)

Last tetanus shot_________________(year)
HPV/ Gardasil Vaccine series completed? _YES_NO
Have you had the Hepatitis B series? _YES_ NO

Anyabnormal Pap smears? _YES_NO
Cervical Dysplasia (precancerous cells of the cervix)? _YES_NO

If yes, any treatment? Dates:
LEEPLaser ____________________________
Cryo (freezing) _________________________
Cone Biopsy ___________________________

Medical History: Do you now have or have you ever had:

- ❑ Asthma
- ❑ Autoimmune disorder ________________________
- ❑ Bleeding Disorder
- ❑ Blood transfusion
- ❑ Bone/Joint Disease
- ❑ Cancer (type?)
- ❑ Chicken pox/shingles
- ❑ Chlamydia
- ❑ Deep Vein. Thrombosis
- ❑ Depression
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Elevated cholesterol
- ❑ Endometriosis
- ❑ Fibroids (type?)_______
- ❑ GERD/Reflux
- ❑ G.I. Illness___________
- ❑ Gestational Diabetes
- ❑ Gonorrhea
- ❑ Heart Disease
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Herpes
- ❑ Infertility
- ❑ Irritable Bowel Syndrome
- ❑ HIV
- ❑ HPV/genital warts
- ❑ High Blood Pressure
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Liver Disease
- ❑ Migraines
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Pelvic inflamm. disease
- ❑ Seizures
- ❑ Sleep Apnea
- ❑ Syphilis
- ❑ Trauma
- ❑ Tuberculosis

Other:____

Family History: Include the age of onset and type of cancer.

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other Relative
Cancer (type)									
Diabetes (type)									
DVT									
Heart Disease									
Osteoporosis									

<u>Reproductive History:</u> Menstrual Cycle

Age at first period?___________ If menopausal, age of menopause: ___________

How often fo you get your menstrual cycle? Every _____ days, lasting _____ days.

Are your cycles? ❑ Regular ❑ Irregular

Are you sexually active? ❑ Never ❑ Not currently ❑ Yes

Method of contraception:

❑ Not Needed ❑ Vasectomy ❑ Rhythm Method ❑ Implanon ❑ Tubal Ligation

❑ None ❑ Condoms ❑ NuvaRing ❑ Mirena IUD ❑ Essure

❑ Pill ❑ Patch ❑ Depo Provera ❑ ParaGuard IUD ❑ Other___________

<u>Obstetrical History</u>

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal, C/S, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal

Complications: *Examples:* preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.
If preterm labor, were medications used?

PAST PREGNANCIES

Birthdate	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location

<u>Social History:</u>

Occupation:____

Are you? ❑ Married ❑ Single ❑ Engaged ❑ Significant other ❑ Divorced ❑ Widowed ❑ Same Sex Partner

Significant other's name:____ Phone#:_______________________

Other emergency contact name:____ Phone#:_______________________

Tobacco Use: ❑ Never ❑ Current ________ # of Cigarettes per day ❑ Former, Quit at age ________

Any alcohol use? YES NO *If yes, the average number of drinks per week_____________________

Do you use street drugs? YES NO *If yes, the type used and last use________________________________

How many times and how long per week do you exercise? (circle) 1X 2X 3X 4X 5X+

Per session: 20 mins. 30 mins. 45 mins. 60+ mins.

Do you eat a healthy diet? ❑ Daily ❑ Some ❑ No

Any history of violence or abuse in your current household or in your past? ❑ NO ❑YES

Do you have any cultural or religious considerations that need special attention? ❑ NO ❑ YES

***Subject to the needs of your health, a scheduled appointment may be changed by the provider to a different type of appointment. _______ (Please Initial)

Patient Signature____ Date:____________________________________