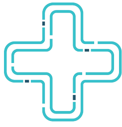

Gynecology Questionnaire

Signature OB/GYN

Name ______________________________ Date: __________ Date of Birth* ______________

Age __________ Race* ____________ Ethnicity* ____________ Primary Language* ____________

Pharmacy ______________________________ *Required by Healthcare/Meaningful Use Legislation.

Reason for Today's Visit: ______________________________

Medicines & Allergies:

Current medications & dosage

____

____

____

____

Drug Allergies: ______________________________

____

____

Please list any hormones or birth control you are taking:

____

____

____

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

- ☐ Asthma
- ☐ Autoimmune disorder ______________
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer (type?) __________
- ☐ 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
- ☐ Pain/Burning/ Frequency with Urination
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis
- ☐ Trichomonas

Other: ______________________________

Surgical History: Please list ALL surgical procedures, including year:

____

____

____

____

____

____

____

Please check if you have had any of the following:

- ☐ Total Abdominal Hysterectomy
- ☐ Total Vaginal Hysterectomy
- ☐ Laparoscopic Supracervical Hysterectomy
- ☐ Robotic-Assisted Total Hysterectomy
- ☐ Bilateral Salpingo Oophorectomy (both tubes & ovaries removed)
- ☐ Left Salpingo Oophorectomy (left tube & ovary removed)
- ☐ Right Salpingo Oophorectomy (right tube & ovary removed)

PLEASE COMPLETE BOTH SIDES

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

Last bone density exam _________________(year)
Last colonoscopy_______________________(year)
Last mammogram ________(year) Location ________________
Last Pap smear___________________(month/year)

Traveled out of country in last month? ____ YES __ NO
HPV/ Gardasil Vaccine series completed? ____ YES __ NO
Have you had the Hepatitis B series? ____ YES __ NO

Any abnormal Pap smears? ______YES____NO
Cervical Dysplasia (precancerous cells of the cervix)? ______YES____NO

If yes, any treatment? Dates:
LEEP ______________________________
Laser ______________________________
Cryo (freezing) ______________________________
Cone Biopsy ______________________________

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)									
Heart Disease									
Osteoporosis									

Social History
Occupation:____

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

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 ______________________________

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

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

Reproductive History: Menstrual Cycle
Age at first period? ______ If menopausal, age of menopause: _______ **First day** of last period: ______________

How often do 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 ☐ Nexplanon ☐ Tubal Ligation
☐ None ☐ Condoms ☐ NuvaRing ☐ Liletta IUD ☐ Essure
☐ Pill ☐ Patch ☐ Depo Provera ☐ ParaGuard IUD ☐ Ablation
Other ____

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

Type: vaginal, C/S, forceps, or vacuum

PAST PREGNANCIES

	Birthdate	Weeks	Type of delivery
EXAMPLE:	01/15/75	40	Vaginal

*****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: ______________________________

PLEASE COMPLETE BOTH SIDES