Gynecology Questionnaire

OB/GYN

Name _____ Date: _____ Date of Birth* _____

Age _____ Race* _____ Ethnicity* _____ Primary Language* _____

*Required by Healthcare/Meaningful Use Legislation.

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

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 _____

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
- ☐ Chicken pox vaccination
- ☐ 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: _____

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

_____
_____
_____
_____
_____
_____

Medicines & Allergies:

Current medications & dosage _____
_____
_____
_____

Vitamins/herbal supplements _____
Drug allergies _____
Reaction _____

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)									
Psychiatric									
Hypertension									
Blood Clots									
Osteoporosis									
Other									

PLEASE COMPLETE BOTH SIDES

Reproductive History: Menstrual Cycle

Age at first period? _____ Day of last period: _____ If menopausal, age of menopause: _____

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 ☐ Implanon ☐ Tubal Ligation
☐ None ☐ Condoms ☐ NuvaRing ☐ Mirena IUD ☐ Essure
☐ Pill ☐ Patch ☐ Depo Provera ☐ ParaGuard IUD ☐ Other_____

Obstetrical History

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
EXAMPLE:	01/15/75	40	12	6 lb. 2 oz.	F	Vaginal	Epidural	HBP. Gest. Diabetes.	HCGH

Social History

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: _____

PLEASE COMPLETE BOTH SIDES

Last Update: July, 2017