GYN Questionnaire

Name_______________________________ Age: ___ DOB: ___/___/___ Height______ Date: ___/___/____

List your Primary Care Physician: _____________________________ Last menstrual period: _____________________

Reason for your visit today: ____

☐ Check Box for ***No Known Drug Allergies***

☐ Check Box for *** **LATEX** Allergy***

List all Allergies & Adverse Reactions

Drug/Allergen Reaction

____

____

Vaccine Immunization (Flu, Tdap, etc…) **& Date received**

____

____

List all Medications/Supplements/Herbal and Dosage

____

____

____

Surgical History (C/S, Appendix, Tubal, Dental, etc…)

Procedure Surgery Date

____

____

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Past Medical History

- ☐ Abuse/Domestic Violence
- ☐ Acid Reflux (GERD)
- ☐ Acne
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune Disorder
- ☐ Bipolar
- ☐ Birth Defects or Inherited Disease
- ☐ Blood Transfusions
- ☐ Breast Cancer
- ☐ Breast Problems
- ☐ Chronic ear infections
- ☐ Crohn's disease
- ☐ Cyst on Breast
- ☐ Cyst on Ovary
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty swallowing
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Endometriosis
- ☐ Fatty Liver
- ☐ Fibrocystic breast
- ☐ Fibromyalgia
- ☐ GI Problems
- ☐ Gallbladder
- ☐ HIV/AIDS
- ☐ Headache/Migraine
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ History of Blood Clot (Lungs or Leg)
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney or Bladder
- ☐ Lipoma
- ☐ Lung Disease
- ☐ Lupus
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Polyps
- ☐ Pre-Eclampsia
- ☐ Psychiatric Illness
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Uterine Fibroids
- ☐ Varicosities
- ☐ Other Types of Cancer:___________ __________________ __________________
- ☐ Other conditions: ____________________ __________________

Family History { **M**-Mother **F**-Father **Son**-Son **D**-Daughter **S**-Sister **B**-Brother **MGM**-Maternal Grandmother **MGF**-Maternal Grandfather **MA**-Maternal Aunt **MU**- Maternal Uncle **O**-Other Relative **PGM**-Paternal Grandmother **PGF**-Paternal Grandfather **PA**- Paternal Aunt **PU**-Paternal Uncle }

Diabetes -	**GI Problems -**
High Blood Pressure -	**Psychiatric Illness -**
Heart Disease -	**Depression -**
Heart Attack -	**Birth Defect -**
High cholesterol -	**Osteoporosis -**
Stroke -	**Breast cancer -**
Thyroid Problems -	**Ovarian cancer -**
Lung Disease -	**Colon cancer -**
Asthma -	**Lung Cancer -**
Arthritis -	**Pancreatic Cancer -**
Seizure Disorder -	**Drug or Alcohol Abuse -**

Social History

1. Smoking Status:
   ☐ Never ☐ Former ☐ Current- every day
2. Tobacco-years of use: ______________________
3. Smoking - How much?
   ☐None ☐1PPW ☐2PPW
4. Has smoked since age: _______________________
5. Chewing tobacco ☐Yes ☐No
6. Illicit drugs ________________________________
7. Alcohol intake:
   ☐ None ☐Occasional ☐Moderate ☐Heavy
8. Caffeine intake:
   ☐ None ☐Occasional ☐Moderate ☐Heavy
9. Diet:
   ☐Regular ☐Diabetic ☐Vegetarian ☐Vegan
   ☐Specific ☐Cardiac ☐Carbohydrate ☐Gluten free
10. Deaf or serious difficulty hearing: ☐Yes ☐No
11. Blind or serious difficulty seeing: ☐Yes ☐No
12. Difficulty concentrating, remembering or making decisions ☐Yes ☐No
13. Difficulty walking or climbing stairs ☐Yes ☐No
14. Difficulty dressing or bathing ☐Yes ☐No
15. Difficulty doing errands alone ☐Yes ☐No
16. Relationship Status:
    ☐Married ☐Single ☐Divorced
    ☐Separated ☐Widowed ☐Domestic partner
17. Are you currently employed? ☐Yes ☐No
18. Occupation: ______________________________
19. Education: High School/ 2yr College/ 4yr College/ Post Graduate
20. Live alone or with others? ☐Alone ☐with others
21. Number of children: _________________________
22. Exercise level:
    ☐None ☐Occasional ☐Moderate ☐Heavy
23. General stress level: ☐Low ☐ Medium ☐ High
24. Sexual orientation
    ☐Heterosexual ☐Homosexual ☐Bisexual
25. Sexually active? ☐Yes ☐No
26. Protected sex? ☐Always ☐Usually ☐No
27. Performs monthly self-breast exam ☐Yes ☐No
28. Seat belts used routinely ☐Yes ☐No
29. Sunscreen used routinely ☐Yes ☐No
30. Is blood transfusion acceptable in an emergency? ☐Yes ☐No
31. Advance Directive? ☐Yes ☐No

GYN History

1. Last menstrual period: ______________
2. LMP ☐Unknown ☐Approximate ☐Definite
3. Menses Monthly: ☐Yes ☐No
4. Flow: ☐Light ☐Normal ☐ Heavy
5. Duration of flow (days) _____________
6. Frequency of cycle (Q days) __________
7. What age did you start your period _____
8. Current birth control method:
   ____
9. Desired birth control method ☐Yes ☐No
10. Date of last pap smear ______________
11. Abnormal Pap: ☐Yes ☐No
12. When? ____________________________
13. Cervical biopsy: ☐Yes ☐No
14. Leep or Cryo Therapy ☐Yes ☐No
15. List your age with first child __________
16. If post-menopausal, age at Menopause: ______________________
17. Hormone replacement therapy ☐Yes ☐No
18. Post-menopausal Bleeding? ☐Yes ☐No
19. HPV Vaccine ☐Yes ☐No
20. Sexual problems? ☐Yes ☐No
21. History of STDs:
    Choose all that apply:
    HPV/Chlamydia/Herpes/Gonorrhea/Trichomonas/Syphilis/Hepatitis/HIV
    List___________________________
22. Hernia Repair ☐Yes ☐No
23. Staph/ MRSA infection ☐Yes ☐No
24. Ovarian Cysts ☐Yes ☐No
25. Ovary(ies) removed ☐Right ☐Left ☐both
26. Uterine fibroids ☐Yes ☐No
27. Hysterectomy ☐Yes ☐No
    ☐Partial ☐Full Hyst
28. Endometriosis ☐Yes ☐No
29. Vaginal infection ☐Yes ☐No
30. Loss of urine w/ coughing or straining ☐Yes ☐No
31. Bladder repair ☐Yes ☐No
32. Breast lump or biopsy ☐Yes ☐No
33. Bartholin Gland Cyst/ Removal ☐Yes ☐No
34. Urinary Tract Infection ☐Yes ☐No
35. Problem with excess hair ☐Yes ☐No
36. Date of last colonoscopy ____________
37. Date of last mammogram ___________
38. Date of last bone density ____________

Obstetric History

Have you ever been pregnant? ☐Yes ☐No How many times have you been pregnant? _______

Full Term ______Premature______ Miscarriages______ Abortions ______ Ectopic ______ Multiples _____ Living children ______

Date	# Fetuses	Gestational age	Labor Length	Birth Weight	Sex	Delivery Type	Anesthesia	Complications
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		
		Full / Preterm			M / F	Vag / C-Sec		