

OBSTETRICAL AND GYNECOLOGICAL CARE PATIENT QUESTIONNAIRE

Today's Date _____ Do you have a medical advanced directive on file? _____

Patient's Name _____ Age _____ Birth Date _____

Height _____ Weight _____

FAMILY HISTORY: (Include natural parents, siblings, grandparents, aunts, uncles, and children.) Note age at onset if known.

Heart Disease _____ Alcoholism _____ Thyroid Problems _____

High Blood Pressure _____ Depression _____ Cancer & Type _____

Stroke _____ Diabetes _____

Other _____

MEDICAL HISTORY: Do you have or have you ever had any of the following? Mark yes or no.

Diabetes _____ Heart Condition _____ Hemorrhoids _____ Thyroid Condition _____

Asthma _____ Eating Disorder _____ Gastric Reflux Disease _____ Anxiety _____

High Blood Pressure _____ Blood Transfusion _____ IBS _____ Depression _____

Other _____ Have you ever had a test for tuberculosis (mantoux skin test) Yes No If yes, date _____

The result of this skin test was Positive Negative

SURGICAL HISTORY: Have you had any of the following surgeries? Mark yes or no. Give dates if known.

Tonsillectomy _____ Tubal Ligation _____ Appendectomy _____

Hysterectomy _____ Gallbladder _____ D & C _____

Kidney _____ Bladder _____ C-Section _____

Cervical Cryosurgery/LEEP _____ Colonoscopy _____ Other Surgeries _____

ALLERGIES:

Drugs: _____

Food: _____ Other _____

CURRENT MEDICATIONS:

List of medications including the dosage _____

IMMUNIZATIONS: Last Tetanus _____

CURRENT HEALTH PRACTICES:

Check any one of the following habits that may apply and list the average amount consumed per day.

Alcohol (beer, wine, hard liquor) Amount _____ Coffee, Tea, Amount _____ Soda (pop) Amount _____

Street drug use: Yes No If yes, type _____

Tobacco: Type _____ Age started _____ Average Daily Amount _____

Still use: Yes No Do you wish help in stopping smoking? Yes No Did you use tobacco but stopped: Yes No

Check the word that applies to your use of seatbelts: Always Sometimes Never

Do you exercise regularly? Yes No If yes, type of exercise _____

If you are on a special diet, describe _____

Describe the dairy products and the amount that you consume _____

Frequency of dental checkup: _____ Frequency of eye exam: _____

Do you feel safe in your relationship with your partner? (yes or no) _____

MENSTRUAL HISTORY:

Age of first menstruation _____ Menopause: Yes _____ No _____ When _____

Number of days your period usually lasts _____

Number of days from 1st day of one period to the 1st day of the next _____

of pregnancies _____ # of children _____ Miscarriages _____ Abortions _____

First day of last menstrual period (date) _____ Last pap smear (date) _____

Method of Birth Control (please circle) Pills Patch Condoms IUD Ring Depo Provera Implanon None Other _____

Have you had a tubal ligation? (yes or no) _____ Has your partner had a vasectomy? _____

(over)

YES NO UNSURE

_____ Abnormal pap smear in the past? If yes, when? _____ HPV detected? (yes or no) _____
 _____ Sexual intercourse before 18 years old or history of venereal warts or
 _____ history of four or more sex partners?
 _____ Natural mother or sister have history of breast or ovarian cancer?

REVIEW OF SYSTEMS:

YES NO UNSURE GENERAL

_____ Recent weight change
 _____ Fever, chills or night sweats
 _____ Increase drinking or urinating
 _____ Lumps or masses
 _____ Dizziness or lightheadedness
 _____ Fainting
 _____ Headaches
 _____ Itching
 _____ Rashes or skin problems
 _____ Thyroid disorder
 _____ Cancer
 _____ Easy bruising or bleeding
 _____ Fatigue
 _____ Always hot or cold

BREASTS

_____ Lumps
 _____ Tenderness
 _____ Drainage from nipple
 _____ Monthly breast self-examination

EYE, EAR, NOSE & THROAT

_____ Eye pain
 _____ Glaucoma
 _____ Blurred or double vision
 _____ Use glasses or contact lenses
 _____ Loss of hearing
 _____ Ringing in ears
 _____ Drainage from ears
 _____ Trouble with nose or sinuses
 _____ Teeth or gum problems
 _____ Use dentures
 _____ Hoarseness
 _____ History of radiation therapy to head or neck

RESPIRATORY

_____ Recent cough
 _____ Recent Sputum (phlegm) production
 _____ Pneumonia or pleurisy
 _____ Shortness of breath with activity
 _____ Wheezing or asthma
 _____ Pulmonary emboli (blood clot to the lung)

CARDIOVASCULAR

_____ Palpitations
 _____ Chest pain
 _____ Heart disease
 _____ Rheumatic fever
 _____ Ankle swelling
 _____ Shortness of breath at night
 _____ Pain in legs with minimal activity (eg. walking 6 blocks or 2 flights of stairs)
 _____ Blood clots (thrombophlebitis)
 _____ Difficulty breathing when lying flat

YES NO UNSURE GASTROINTESTINAL

_____ Heartburn
 _____ Abdominal pain
 _____ Nausea or vomiting
 _____ Bloating or food tolerances
 _____ Peptic ulcer disease
 _____ Liver disease
 _____ Jaundice
 _____ Gallbladder disease
 _____ Diarrhea
 _____ Constipation
 _____ Black tarry stool

GENITOURINARY

_____ Do you get up at night to urinate?
 _____ Pain or burning with urination
 _____ Difficulty starting or holding urine
 _____ Urinary or bladder infections
 _____ Kidney or bladder stones
 _____ Blood in the urine
 _____ Genital Warts
 _____ Gonorrhea, syphilis, or chlamydia
 _____ Genital herpes
 _____ Pain or other problems with intercourse
 _____ Possibly pregnant
 _____ Change in menstrual pattern
 _____ Disabling menstrual cramps
 _____ Unusual vaginal discharge or bleeding
 _____ Did your mother take "DES" (Diethylstilbestrol) when pregnant with you?
 _____ PMS (Premenstrual Syndrome)
 _____ Other (describe)

MUSCULOSKELETAL

_____ Neck or back pain
 _____ Joint problems
 _____ Muscle weakness
 _____ Night cramps
 _____ Use a brace or splint
 _____ Any other concerns you wish to discuss

Please list your main concern for today's visit

