



Name:
Age:
DOB:
DATE:

GYNECOLOGY HEALTH QUESTIONNAIRE

Briefly describe what you want to discuss with your provider today:

PERSONAL HEALTH HISTORY

Number of pregnancies: _____ Number of live births: _____
 Cesarean: _____ Vaginal Deliveries: _____ Miscarriages: _____ Abortions: _____ Ectopic: _____

First day of last menstruation: __/__/__ Age at first menstruation: _____
 Period every ____ days. Period lasts ____ days.
 Date of last Pap smear: __/__/__ Prior treatment for abnormal Pap smears? Yes No
 Please circle any that apply of the following:

- irregular periods spotting heavy periods acne abnormal hair growth
- excessive pelvic pain pain with intercourse pain with pelvic exam

Are you sexually active (within the past 6 months)? Yes No
 Current birth control method: _____ Previous birth control methods: _____
 History of sexually transmitted disease? Yes No. If yes, please list type: _____

Date of last Mammogram: __/__/__ Date of last colonoscopy: __/__/__

List any medical problems you have or have had (please add information below if need):

Year	Diagnosis

List any prior surgeries you have had (please add information below if need):

Year	Procedure	Hospital or Doctor

List your prescription medications, vitamins, herbal products, and over the counter drugs:

Drug	Strength	Frequency of dose

List any allergies to medications, food or latex (please add information below if need):

Name of Drug	Reaction you had

Please add information here if need be and then continue on the other side.

HEALTH HABITS AND PERSONAL SAFETY

Describe your exercise habits:

Sedentary Mild Exercise (weekends) Occasional (< 4x/wk) Vigorous (>= 4x/wk)

How many diary items (milk, yogurt, cheese, ice cream) do you have in a day? _____

Do you follow a special diet? Yes No Describe: _____

Do you smoke? Yes No If yes: # packs per day # of years smoking

Do you drink alcohol? Yes No Please enter the number of drinks per week: _____

Do you use or have you used recreational or street drugs Yes No

Do you feel safe at home? Yes No

Would you like to discuss anything related to sexuality? Yes No

Would you like to discuss anything related to domestic / sexual abuse? Yes No

Marital Status: Single Partner Married Separated Divorced Widow

What is your occupation? _____

FAMILY HEALTH HISTORY

Has anyone in your family had:

Ovarian cancer? No Yes (Relationship to you/age at diagnosis) _____

Breast cancer? No Yes (Relationship to you/age at diagnosis) _____

Colon cancer? No Yes (Relationship to you/age at diagnosis) _____

Heart attack before age 55? No Yes (Relationship to you) _____

Stroke before age 55? No Yes (Relationship to you) _____

Diabetes? No Yes (Relationship to you/age at diagnosis) _____

REVIEW OF SYSTEMS

None

Please circle any problems you have in the following areas:

General: unexplained weight loss	hot flashes	night sweats
Ears Nose Throat: cough	seasonal allergies	hearing deficit
Lungs: asthma,	shortness of breath	
Heart: palpitations,	pain or pressure	irregular rate or rhythm
Back: pain	weakness	
Digestion: food allergies	gas	bloating
Bowels: constipation,	diarrhea	pain
Bladder: frequent infections	blood in the urine	blood in the stools
Endocrine: diabetes	low blood sugar	thyroid
Sexual Function: pain with intercourse	lack of desire	painful urination
Psychiatric: depression	anxiety	mood swings
		panic attacks
		insomnia

PROVIDER PLAN

SBE Mammography Stool guiac
 Pap STD screen EMB
 Urine dip Urine C+S Urine pregnancy test
 BMD
 TVUS Office hysteroscopy
 Blood work CA-125 Surgery

PQRI reminder questions:

Did you ask about incontinence symptoms?

Did you evaluate for osteoporosis?

Reviewed by: _____