GYNECOLOGIC HISTORY QUESTIONNAIRE

Name:_____ DOB: _____ Date: _____

Chief reason for today's visit: _____

First day of last menstrual period: _____

Date of last pap smear: _____Results: _____

Type of birth control currently using: _____
(including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this method of birth control? _____

Were you referred to our office? If so please tell us by who._____

OBSTETRICAL HISTORY

Are you currently pregnant? ☐**Y** ☐**N** If so, on what date was first positive pregnancy test? _____

Total number of times pregnant (include miscarriages and abortions): _____

Total number of live births (include dates and type of delivery): _____

_____

Total number miscarriages: _____ Total number abortions: _____

Any complications during your pregnancies? If so, please explain: _____

_____

Did you have a Caesarean Section? If so, when: _____

Any family history of inherited disorders (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder)?

_____

GYNECOLOGICAL HISTORY

Age at first period: _____ How many days do your periods last? _____

How often do your periods come? □ Every 28-30 days □ More frequently □ Less frequently

How heavy is your menstrual flow? □ Light □ Moderate □ Heavy □ Extremely Heavy

Do you have bad cramps? ☐**Y** ☐**N** Do you have any PMS symptoms? ☐**Y** ☐**N**

Any bleeding between periods? ☐**Y** ☐**N** Any bleeding after intercourse? ☐**Y** ☐**N**

Any problems with urination (loss of urine while coughing, sneezing, etc.)? ☐**Y** ☐**N**

Check any of the following problems that you have had either in the past or currently:

□ Gonorrhea □ Pelvic Inflammatory Disease (PID) □ Herpes □ Vaginal Infections

□ History of physical or sexual abuse □ IUD Related problems

□ Abnormal pap smears (what abnormality and when)? _____

******MORE QUESTIONS ON THE OTHER SIDE OF THIS SHEET*******

MEDICAL HISTORY

How is your health in general? □ Excellent □ Good □ Fair □ Poor

Do you smoke? **□Y □N** How much? _____packs per day How many years have you smoked?_____

Are you a past smoker? **□Y □N** When did you quit? _____ How many years did you smoke? _____

Do you drink alcohol? **□Y □N** How many alcoholic beverages do you have in a week? _____

Social drug use? **□Y □N** If so, what type of drugs do you use? _____

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? _____

_____

Have you ever been hospitalized for a medical illness? If so, please explain: _____

_____

What surgeries have you had? (please give year of surgery, including cosmetic): _____

_____

_____

Do you have any allergies to medications? **□Y □N** Do you have any other allergies? **□Y □N**

Please List: _____ Please list: _____

_____ _____

_____ _____

Do you have any history of a bleeding disorder? **□Y □N** Had a blood transfusion? **□Y □N**

Do you use medication on a regular basis? Please list name and dose of medication: _____

_____

Have you had a mammogram? **□Y □N** Date & result of last mammogram: _____

Do you have any problems with your breasts? (lumps, discharge, or pain)? _____

FAMILY HISTORY (Please check if anyone in your family has any of these conditions and tell us who has it)

□ Breast Cancer □ Uterine Cancer □ Ovarian Cancer □Colon Cancer

□ Diabetes □ Heart disease □ High Blood Pressure □ Stroke

□ Osteoporosis □ Thyroid disease □ Autoimmune □ Other

SOCIAL HISTORY

Marital status: **□M □S □D □W □P** Sexual Orientation? **□Heterosexual □Homosexual**

Occupation: _____ Religion: _____