Gynecology patient History Questionnaire

The answers to this form will help your provider understand your medical concerns and conditions.

Name: **Age (years)**: **Today's date:**

Referred by:

Are you here for: ☐ Annual Exam? ☐ Problem?

Please describe your problem if any:

- **Please list below all the changes that have occurred since you were last seen here:**

Medication: ☐ No changes ☐ _____

Pharmacies: ☐ No changes ☐ _____

Other Physicians: ☐ No changes ☐_____

Surgeries/hospitalization: ☐ No changes ☐ _____

Medical problems: ☐ No changes ☐ _____

Family diseases (mother, father, siblings, children): ☐ No changes ☐ _____

_____

- **Gynecology**

Monthly periods? ☐ Yes ☐ No Time from start of one to start of next:_____
Last normal menstrual period: _____ Total number of days bleeding:_____
Number of heavy days: _____ Average tampon/pad (*circle one or both*) use on a normal day: _____
Are you currently sexually active? ☐ Yes ☐ No Do you have a new partner? ☐ Yes ☐ No
Current partner for how long? _____
Would you like testing for sexually transmitted diseases? ☐ Yes ☐ No

Current contraception: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Patch ☐ Pill ☐ NuvaRing
☐ Natural Family Planning ☐ Vasectomy ☐ Tubal ☐ Other: _____

- **Social**

Occupation:_____ Number of children: _____

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widow ☐ living together

Do you exercise regularly? ☐ Yes ☐ No Routine:_____

Type of exercise:_____

Patient's Name _____

- **Vaccines**

☐ Yes ☐ No Are you up-to-date with your tetanus/diphtheria/acellular pertussis (whooping cough) vaccine? When? _____

☐ Yes ☐ No Are you up-to-date with Gardasil/HPV vaccine? (patients age 9 to 26 years)

☐ Yes ☐ No Are you up-to-date with the flu-shot?

☐ Yes ☐ No Have you had the shingles vaccine? When?

☐ Yes ☐ No Have you had Prevnar 13 for pneumonia prevention? When?

☐ Yes ☐ No Have you had Pneumovax? When? _____

☐ Yes ☐ No Do you want any vaccine(s) today? Which ones?_____

- **Tobacco/Alcohol/Diet**

Have you ever used tobacco products? ☐ Yes ☐ No Quit date:

Current tobacco users: packs per day:_____ Are you interested in quitting? ☐ Yes ☐ No

Use of alcohol ☐ Never ☐ Rarely ☐ Frequently ☐ Amount_____

Is your use of alcohol a concern for you or others? ☐ Yes ☐ No

Do you drink caffeine beverages? ☐ Yes ☐ No ☐ coffee ☐ tea ☐ soda ☐other: _____

How many cups or bottles a day? _____ cups _____ bottles

Are you currently dieting? ☐ Yes ☐ No Which diet? _____

- **Other Health Concerns**

Are you in a stable relationship? ☐ Yes ☐ No _____

Does your partner mistreat you or the kids? ☐ Yes ☐ No _____

Any family violence? ☐ Yes ☐ No _____

Have you been threatened or hurt by anyone? ☐ Yes ☐ No _____

Your current sexual partner(s) is/are: ☐ male ☐ female ☐ none

Do you take calcium supplementation? ☐ Yes ☐ No How much a day?_____

Do you eat/drink dairy products regularly? ☐ Yes ☐ No How much a day?_____

Have you traveled outside the USA recently? ☐ Yes ☐ No _____

Do you use tanning beds regularly? ☐ Yes ☐ No _____

Are you happy with your weight? ☐ Yes ☐ No _____

Are you under a lot of stress lately? ☐ Yes ☐ No Why? _____

Do you have a Living Will/Medical Directive? ☐ Yes ☐ No _____

Any other issues you want to discuss today?_____

FOR NURSES ONLY:

BP: _____ Weight: _____(prior)_____ Height: _____(prior)_____ G ___P ____

LMP:_____ Paps: _____ Abnormal Pap: ☐ Yes ☐ No

Other: _____

Pharmacy: _____ Mail Order: ☐ Yes ☐ No Needs Script: _____

	Dates			Comments
Last pap smear	_____	Normal	☐ Yes ☐ No	_____
Last mammogram	_____	Normal	☐ Yes ☐ No	_____
Last bone scan	_____	Normal	☐ Yes ☐ No	_____
Last cholesterol	_____	Normal	☐ Yes ☐ No	_____
Last colonoscopy	_____	Normal	☐ Yes ☐ No	_____

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