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Obstetrics and Gynecology

PATIENT HISTORY QUESTIONNAIRE

Patient Name: _____ Patient Date Of Birth: _____

A

1. Marital Status: ☐ Single ☐ Married ☐ Long term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: _____
3. Referring Physician: _____
4. Occupation: _____
5. Preferred phone number: _____ confidential voice mails OK: ☐ Yes ☐ No
6. Partner: _____ ☐ None 7. Age of partner: _____
   last first 8. Occupation of partner: _____

B MENSTRUAL HISTORY(complete even if post-menopausal or no longer having periods)

7. Age at first period: _____ years.
8. If your menstrual periods are regular; periods start every: _____ days
9. If your menstrual periods are irregular; periods start every: ____ to ____ days (e.g.,12 to 60)
10. Duration of bleeding: _____ days
11. Does bleeding or spotting occur between periods? Yes ☐ No ☐
12. Does bleeding or spotting occur after intercourse? Yes ☐ No ☐
13. First day of last menstrual period _____
    month day year
14. Is pain associated with periods? Yes ☐ No ☐ Occasionally ☐
15. If yes to 14, is it: before menses? ☐ during menses? ☐ both? ☐

C PREGNANCY HISTORY (All pregnancies) **Have never been pregnant** ☐

16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of delivery or Abortion	Duration Preg.	Hrs. of Labor	Type of Delivery	Complications Mother and/or Infant	CHILD Sex	CHILD Birth Weight	CHILD Present Health

D BIRTH CONTROL HISTORY

17. What birth control method(s) do you currently use? _____

E SEXUAL HISTORY

18. Do you have a sexual partner? No ☐ Yes ☐ (Male ☐ Female ☐)
19. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes ☐ No ☐

REVIEW OF SYSTEMS **Please circle all that are applicable (within the last 6-12 months)**

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Negative
- ☐ feeling poorly
- ☐ feeling tired
- ☐ recent weight gain
- ☐ recent weight loss

EYES
- ☐ Eye Pain
- ☐ Wearing glasses
- ☐ Negative
- ☐ spots before eyes
- ☐ vision changes
- ☐ dry eyes
- ☐ itchy eyes

EAR/NOSE/THROAT
- ☐ Earaches
- ☐ Loss of hearing
- ☐ Negative
- ☐ nose bleeds
- ☐ sinus problems
- ☐ sore throat
- ☐ dental problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Negative
- ☐ heart rate is fast
- ☐ heart rate is slow
- ☐

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Negative
- ☐ cough
- ☐ shortness of breath on exertion
- ☐ shortness of breath with lying flat
- ☐ respiratory distress in sleep

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Nausea
- ☐ Negative
- ☐ constipation
- ☐ diarrhea
- ☐ early satiety
- ☐ heartburn
- ☐ black stool
- ☐ blood in stool

OB/GYN GU
- ☐ Frequency
- ☐ urination at night
- ☐ pain with urination
- ☐ Negative
- ☐ blood in urine
- ☐ cloudy urine
- ☐ odor in urine
- ☐ incomplete emptying of bladder
- ☐ loss of urine with coughing/laughing
- ☐

OB/GYN
- ☐ Abnormal bleeding
- ☐ Irregular menses
- ☐ Pain with menses
- ☐ Pain with intercourse
- ☐
- ☐ Negative
- ☐ vulvar itching
- ☐ midcycle bleeding
- ☐ bleeding after intercourse
- ☐ vulvar pain
- ☐ decreased libido
- ☐ vaginal itching
- ☐ pelvic pain
- ☐ vaginal dryness
- ☐ vaginal discharge
- ☐ vaginal odor

MUSCULOSKELETAL
- ☐ joint pain
- ☐ Negative
- ☐ joint swelling
- ☐ joint stiffness
- ☐ limb pain
- ☐ limb swelling

INTEGUMENTARY (SKIN)
- ☐ Acne
- ☐ Breast discharge
- ☐ Negative
- ☐ itching
- ☐ change in a mole
- ☐ breast pain
- ☐ breast lump

NEUROLOGICAL
- ☐ Confused
- ☐ Memory problems
- ☐ Negative
- ☐ dizziness
- ☐ headaches/migraines
- ☐ limb weakness
- ☐ difficulty walking

PSYCHIATRIC
- ☐ Suicidal
- ☐ Sleep disturbances
- ☐ Negative
- ☐ anxiety
- ☐ depression
- ☐ change in personality
- ☐ emotional problems

ENDOCRINE
- ☐ Hair loss
- ☐ Hot flashes
- ☐ Heat/cold intolerance
- ☐ Negative
- ☐ muscle weakness
- ☐ deepening of the voice
- ☐ feeling weak
- ☐ dry skin

HEMATOLOGY/IMMUNOLOGY
- ☐ Easy bleeding
- ☐ seasonal allergies
- ☐ Negative
- ☐ swollen glands
- ☐ easy bruising

I PAST MEDICAL HISTORY Check any that apply: or ☐ None

☐ Arthritis
☐ Diabetes:
  ☐ Diet controlled
  ☐ Pill controlled
  ☐ Insulin controlled
☐ High blood pressure
☐ Heart disease
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder
☐ Other: _____
☐ Anxiety, Depression

J CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

K DO YOU CURRENTLY?:

28. Smoke No ☐ Yes ☐ ____ packs/day
29. Use alcohol No ☐ Yes ☐ __ wine (glasses/day); __ beer (bottles/day); __ hard liquid (oz./day)

30. Use illicit drugs No ☐ Yes ☐ _____ type _____ amount
31. Exercise: Type: _____ How often _____

L DRUG ALLERGIES

32. No ☐ Yes ☐ List: Drug & Reaction

_____
_____
_____

M FAMILY HISTORY

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other _____
☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer _____

If "yes" to any, please list affected relatives

_____ _____
_____ _____

☐ None of the above.

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

20. Check any that apply: or ☐ None

SURGERY	YEAR
☐ D&C	
☐ hysteroscopy	
☐ infertility surgery	
☐ tuboplasty	
☐ tubal ligation	
☐ laparoscopy	
☐ hysterectomy (vaginal)	
☐ hysterectomy (abdominal)	
☐ myomectomy	

SURGERY	YEAR
☐ ovarian surgery	
☐ L cyst(s) removed ovarian	
☐ R cyst(s) removed ovarian	
☐ L ovary removed	
☐ R ovary removed	
☐ vaginal or bladder repair for prolapsed or incontinence	
☐ cesarean section	
☐ other (specify) _____	

G PAST SURGICAL HISTORY (Not OB/GYN)

21. List all surgeries and their year or ☐ None

Surgeries	Year

H PAP SMEAR/MAMMOGRAM HISTORY

22. ☐ Date of last pap smear: _____
23. ☐ Have you had abnormal pap smears? No ☐ Yes ☐
24. ☐ Have you had treatment for abnormal smears? No ☐ Yes ☐

If yes, what type(s) of treatment have you had?

	YEAR
cryotherapy	
laser	
cone biopsy	
loop excision (LEEP)	

25. Date of last mammogram: _____ (month) _____ (year)
26. Have you had an abnormal mammogram? No ☐ Yes ☐

OTHER PAST GYNECOLOGICAL HISTORY

27. Check any that apply: ☐ None ☐ Genital warts ☐ Herpes – genital ☐ Syphilis
☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea
☐ Vaginal infections ☐ Other _____