

## PATIENT QUESTIONNAIRE

To ensure optimal health care for you, please provide the information requested below to better assess your health needs. All information on your record is confidential and cannot be released without your written permission. Answering questions is optional. If you decline to answer, it will not affect your care.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Date \_\_\_\_\_ Primary Care M.D. \_\_\_\_\_

Reason for your visit \_\_\_\_\_

### GYNECOLOGIC HISTORY

Date of last pelvic exam: \_\_\_\_\_

- No Yes** Have you had:
- Abnormal Pap smears.
- Vaginal infections:  Yeast  Bacterial (BV)
- Sexually transmitted infections:  Syphilis  Gonorrhea  Chlamydia  Herpes  
 Hepatitis B or C  Warts  HIV/AIDS  Trichomonas  Other \_\_\_\_\_
- Endometriosis
- Pelvic Infection or Inflammatory Disease
- Infertility
- Current method of birth control: \_\_\_\_\_
- Sexual difficulty (eg. Bleeding, pain, difficulty with sex drive, difficulty with orgasm)
- Are you postmenopausal?
- If you are postmenopausal, do you have:  vaginal dryness  vaginal bleeding  hot flashes  night sweats
- Are you having periods?  
 Age at 1<sup>st</sup> menstrual period \_\_\_\_\_ 1<sup>st</sup> day of last menstrual period \_\_\_\_\_  
 Periods are:  regular  irregular Number of days of flow (average) \_\_\_\_\_  
 Length of cycle (days) \_\_\_\_\_  Bleeding between periods
- Do you have cramping:  mild  moderate  severe
- Abnormal heavy bleeding:  frequent changes of pad/tampon  
 Clots  Gushes  Night floods
- PMS:  Irritability  Anxiety  Moodiness  Depression
- Abnormal discharge

### PREGNANCY HISTORY

#of pregnancies: \_\_\_ Live Births: \_\_\_ Miscarriages: \_\_\_ Abortions: \_\_\_ Ectopic (tubal) pregnancies: \_\_\_ Adopted: \_\_\_

### YOUR CHILDREN'S BIRTH INFORMATION

| #  | BIRTHDATE | WEIGHT | SEX | OB DOCTOR | COMPLICATIONS (include cesarean sections) |
|----|-----------|--------|-----|-----------|---|
| 1. |           |        |     |           |   |
| 2. |           |        |     |           |   |
| 3. |           |        |     |           |   |
| 4. |           |        |     |           |   |

### FAMILY HISTORY

**Have any family members had (include parents, grandparents, aunts, uncles, siblings, cousins) :**

- Heart attack or stroke before age 55  High cholesterol
- High blood pressure  Diabetes  Thyroid Disease
- Osteoporosis, frequent fractures  Mental Illness:  Depression  Anxiety  Other
- Birth defects: list which family member (if currently pregnant, include father of baby's family) \_\_\_\_\_
- \_\_\_\_\_
- Cancer: Breast: \_\_\_\_\_ Prostrate: \_\_\_\_\_  
 Ovarian: \_\_\_\_\_ Uterine: \_\_\_\_\_ Colon: \_\_\_\_\_

