M A G N O L I A

– O B / G Y N –

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Gynecology Questionnaire

Name: _____ DOB: _____ Date:_____

Reason for today's visit? □ Annual Exam □ Problem: Explain_____

Who is your Primary Care Provider? _____

GYNECOLOGICAL HISTORY

1. First day of last period: _____
2. At what age did you start your periods?_____ (If you do not have periods, please skip to question 5)
3. How often do you have your periods? _____ How long do they last? _____
4. How is your flow? □ Heavy □ Light □ Moderate Do you have pain with your period? □ Yes □ No
5. What is your current method of birth control? _____
6. What age did your period stop? _____ Are you taking Hormone Replacement? □ Yes □ No
7. Do you have any spotting? □ Yes □ No Do you leak urine? □ Yes □ No
8. Have you ever had any of the following?

   □ Gonorrhea □Chlamydia □ Genital Herpes □ Genital Warts □ Syphilis
9. Date of last PAP smear? _____ Have you ever had an abnormal PAP? □ Yes □No
10. Date of last mammogram? _____ Have you been evaluated for infertility? □ Yes □ No
12. Do you have a history of:

    □ Fibroids □ Polyps □ Endometriosis □ Ovarian Cysts

If so, what was done? _____

PAST PREGNANCIES

Date MO/YR	Gestational Age	Birth Weight	Sex	Delivery Type	Complications with Pregnancy/Delivery/Baby

Do you have recurrent miscarriages or have you had a stillbirth? _____

Gynecology Questionnaire cont.

PAST MEDICAL HISTORY

1. Do you or have you had any of the following medical problems?

□ Diabetes □ Heart Disease □ Hypertension
□ Autoimmune Disease □ Seizure Disorder □ History of blood clots in your legs or lungs
□ Hepatitis □ AIDS □ Psychiatric Disorder
□ Thyroid Dysfunction □Asthma □ Involved in a major car accident
□ Bleeding Disorder □ MRSA □ Frequent Urinary Tract Infections
□ Kidney Disease □Sickle Cell Disease/Trait
□ Stroke
□ Cancer- What Type? _____

2. What medications prescriptions are you taking?

_____

3. What over the counter medications or herbal supplements are you taking?_____

4. Are you allergic to any medication? □ Yes □ No If Yes, please list:

_____

Allergic to latex? □ Yes □ No

5. Have you ever been hospitalized? □ Yes □ No
If yes, for what reason? _____

6. Have you ever received a blood transfusion? □ Yes □ No

PAST SURGICAL HISTORY

1. Have you ever had any surgery? □ Yes □ No
If yes, for what reason and when? _____

2. Please list any/all biopsies:

_____

SOCIAL HISTORY

1. Do you smoke? □ Yes □ No How much?

_____

2. Are you a former smoker? □ Yes □ No If so, when did you stop?

:_____

3. Do you drink alcohol? □ Yes □ No How

much?_____

4. Do you use street drugs? □ Yes □ No If so, please list:_____

5. Do you have problems with violence or abuse? □ Yes □ No

6. Do you work outside of the home? □ Yes □ No If so, what type of work? _____

7. Marital Status: □ Single □ Married □ Divorced □ Other

8. Are you sexually active? □ Yes □ No

Gynecology Questionnaire cont.

FAMILY HISTORY / GENETIC HISTORY

1. What is your race or ethnic background? _____

2. Does anyone in your family (parents, grandparents, aunts, uncles, siblings, children) have

□ Neural Tube Defect (spina bifida, anencephaly)
□ Cleft Lip or Palate
□ Congenital Heart Defect
□ Down Syndrome
□ Diabetes
□ Hypertension
□ Autoimmune Disease
□ Thyroid Dysfunction
□ Asthma
□ Stroke
□ Kidney Disease
□ Heart Disease
□ Cystic Fibrosis
□ Mental Retardation
□ Hydrocephalus (water on the brain)
□ Neurological Disorder (including seizures)
□ Deafness or Blindness
□ Any Birth Defect (even if surgically corrected)
□ Any Inherited Problem

□ Huntington's Chorea
□ Psychiatric Disorder
□ Hemophilia
□ Tay-Sachs
□ Muscular Dystrophy
□ Sickle Cell Disease or Trait
□ Thalassemia

□ Other: _____

□ Cancer:

	Family Member	Age of Diagnosis
Breast	_____	_____
Ovarian	_____	_____
Endometrial	_____	_____
Colon	_____	_____

Gynecology Questionnaire cont.

REVIEW OF SYSTEMS

Please check if any of the following symptoms apply to you:

General:
- □ Weight Loss
- □ Weight Gain
- □ Fever
- □ Fatigue

Eyes:
- □ Double Vision
- □ Vision Changes

Ears/Nose/Throat:
- □ Hearing Problems
- □ Sore Throat

Cardiovascular:
- □ Chest Pain/Pressure
- □ Difficult Breathing
- □ Swelling of Legs
- □ Stroke
- □ Other

Gastrointestinal:
- □ Bloody Stool
- □ Nausea/Vomitting/Indigestion
- □ Frequent Diarrhea
- □ Constipation

Urinary:
- □ Blood in Urine
- □ Pain with Urination

Musculoskeletal:
- □ Muscle/Joint Pain

Skin:
- □Rash

Respiratory:

- □ Shortness of Breath
- □ Spitting up Blood
- □ Chronic Cough

Neurological/Psychiatric:

- □ Trouble with Walking
- □ Seizures/Headaches
- □ Depression/Crying Spells

SUMMARY

Is there anything else you feel we should know about that we have not covered?

_____

_____

_____

_____