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

First day of last period: _____

At what age did you start your periods?_____ (If you do not have periods, please skip to question 5)

How often do you have your periods? _____ How long do they last? _____

How is your flow? □ Heavy □ Light □ Moderate Do you have pain with your period? □ Yes □ No

What is your current method of birth control? _____

What age did your period stop? _____ Are you taking Hormone Replacement? □ Yes □ No

Do you have any spotting? □ Yes □ No Do you leak urine? □ Yes □ No

Have you ever had any of the following?

□ Gonorrhea □Chlamydia □ Genital Herpes □ Genital Warts □ Syphilis

Date of last PAP smear? _____ Have you ever had an abnormal PAP? □ Yes □No

Date of last mammogram? _____ Have you been evaluated for infertility? □ Yes □ No

Date of your last Colonoscopy?_____ Date of you last Bone Scan?_____

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

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? _____

Allergic to latex? □ Yes □ No

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

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

PAST SURGICAL HISTORY

Have you ever had any surgery? □ Yes □ No
If yes, for what reason and when? _____
Please list any/all biopsies: _____

SOCIAL HISTORY

Do you smoke? □ Yes □ No How much?_____

Are you a former smoker? □ Yes □ No

If so, when did you stop? :_____

Do you drink alcohol?□ Yes □ No How much?_____

Gynecology Questionnaire cont.

Do you use street drugs? □ Yes □ No

If so, please list:_____

Do you have problems with violence or abuse? □ Yes □ No
Do you work outside of the home? □ Yes □ No If so, what type of work?

Marital Status: □ Single □ Married □ Divorced □ Other

Are you sexually active? □ Yes □ No

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

Respiratory:

□ Shortness of Breath
□ Spitting up Blood
□ Chronic Cough

Gastrointestinal:

□ Bloody Stool
□ Nausea/Vomitting/Indigestion
□ Frequent Diarrhea
□ Constipation

Urinary:

□ Blood in Urine
□ Pain with Urination

Musculoskeletal:

□ Muscle/Joint Pain

Skin:

□Rash

Neurological/Psychiatric:

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