Dedicated to Women
OB-GYN

Patient Questionnaire

If any of these questions do not apply to you, please mark those with "N/A".

Name: _____ _____Age: _____ Date:_____ Last menstrual period_____

Do you have any of the following medical problems? If so, when did symptoms first appear? Please circle and put date.

Diabetes	Osteoporosis	Osteopenia
High Blood Pressure	Glaucoma	Sickle Cell Disease/Trait
High Cholesterol	Hypothyroidism	Migraines
Heart Disease	Hyperthyroidism	Clotting Disorder
Mitral Valve Prolapse	History of Blood Clot in Leg or Lung	
Kidney Disease	Depression	
Asthma	Cancer—What Type?_____	
Arthritis	Other_____	

Have you ever had (circle): chlamydia gonorrhea syphilis herpes HPV (genital warts)
Have you ever had an abnormal Pap? Yes No
If yes, in what year? _____
If yes, did you have any of the following procedures? (Circle those that apply):

Colposcopy and biopsy
Cryosurgery (freezing of the cervix)
LEEP (minor surgery to remove part of the cervix)
Cone biopsy (minor surgery to remove part of the cervix)

Have you completed all or part of the HPV vaccination series? _____ When?_____

Have you had (circle):	Vaginal hysterectomy	Abdominal hysterectomy
	Supracervical hysterectomy	Laparoscopic assisted hysterectomy
	Total laparoscopic hysterectomy	Both ovaries removed

Please list all other operations you have had.

_____ _____
_____ _____

Please list any medications you take regularly (prescription and/or non-prescription). It is not necessary to include dosages.

_____ _____
_____ _____
_____ _____
_____ _____

Please continue on other side →

Please list any drug allergies or enter "none." _____
_____

Please list anyone in your family (parents, siblings, children, grandparents, aunts, uncles, and cousins) with the following diseases:

Diabetes_____
Heart Disease (e.g., heart attacks)_____
High Blood Pressure_____
Osteoporosis _____
Breast Cancer (including age at diagnosis) _____
Ovarian Cancer (including age at diagnosis) _____
Colon Cancer(including age at diagnosis) _____
Blood Clot in the leg_____ Blood Clot in the lung_____

Are your periods regular (about once a month)?_____
Are they painful? Yes No Are they heavy? Yes No
How many days do they last? ____
Have you gone through menopause? Yes No How old were you?_____
Have you had bleeding since menopause?

How many times have you been pregnant? _____ How many vaginal births?_____
How many C-sections? _____ How many miscarriages?_____ How many abortions?_____
How many ectopics? _____

Are you sexually active? Yes No
What do you use for contraception? _____

Do you smoke? Yes No If so, how much?_____ How many years?_____
How often do you drink alcohol and how much do you drink? _____
Do you use recreational drugs (e.g., marijuana, cocaine)? _____
Please circle: Single Married Separated Divorced Widowed Other Relationship
What is your occupation?_____
Race: ___African-American ___Asian ___Caucasian ___Hispanic
___Native American Indian ___Other ___Pacific Islander

Do you exercise regularly? _____ What activity & how many times a week? _____

When was your last Pap smear?_____ Was it normal? Yes No
When was your last Mammogram?_____ Was it normal? Yes No
When was your last Colonoscopy?_____ Was it normal? Yes No
When was your last Bone Density Test?_____ Was it normal? Yes No
When was the last time you had your Cholesterol checked?_____ Was it normal? Yes No
Who is your primary care physician? _____