Sumter OB-GYN

Patient Questionnaire **Name:**_____

Date:_____

PAST MEDICAL HISTORY

(If YOU have EVER had any of these conditions, please indicate with an X)

Breast Conditions

_____ Abnormal Mammogram
_____ Breast Cancer Left Right
_____ Breast Implants
_____ Fibrocystic Breasts
_____ Other _____

Gyn Problems

_____ Abnormal Pap Smear
_____ Bacterial Vaginosis
_____ Cervical Cancer (Neoplasm)
_____ Dysmenorrhea (Painful Periods)
_____ Endometrial (Uterine) Cancer
_____ Endometriosis
_____ Fibroids
_____ Herpes
_____ Human Papilloma Virus Infection (HPV)
_____ Ovarian Cancer
_____ Ovarian Cysts
_____ Pelvic Inflammatory Disease (PID)
_____ Polycystic Ovarian Syndrome (PCOS)
_____ Sexually Transmitted Disease
☐Gonorrhea ☐ Chlamydia
☐Herpes ☐Trichomonas
_____ Vaginal Cancer (Neoplasm)
_____ Vulvar Cancer (Neoplasm)
_____ Other _____

Skin Diseases

_____ Eczema
_____ Moles
_____ Other _____

Heart or Circulation Conditions (Cardiovascular)

_____ Congenital Heart Disease
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ CVA (Stroke)
_____ Hypertension (High Blood Pressure)
_____ Irregular Heart Beat
_____ Mitral Valve Disorders (MVP)
_____ Asthma
_____ Pulmonary Embolism (Blood Clot - Lung)
_____ Thrombophlebitis (Blood Clot in arms or legs)

Endocrine (Glandular) Disorders

_____ Diabetes – Type I (Insulin-Dependent)
_____ Diabetes – Type II
_____ Pituitary Gland Disorder
_____ Thyroid Disease
_____ Other _____

Immune System Diseases

____ Chronic Fatigue Syndrome
____ Systemic Lupus Erythematosis
____ HIV
____ Other _____

Gastrointestinal (GI) Problems

____ Colitis, Ulcerative
____ Crohn's Disease
____ Hepatitis
____ Irritable Bowel Syndrome
_____ Other _____

Kidney Bladder Problem

____ Stress Incontinence
____ Frequent Urinary Infections

Blood (Hematological) Disorders

____ Anemia
____ Bleeding Disorder
____ Clotting Disorder
____ Sickle Cell Trait
____ Sickle Cell Disease
____ Thalassemia
____ Other _____

Musculoskeletal Disorders

____ Arthritis or Joint Pain
____ Arthritis, Rheumatoid
____ Fibromyalgia
____ Osteopenia
____ Osteoporosis
____ Scoliosis
____ Other _____

Neurological Disorders

____ Common Migraines
____ Headaches (Other)
____ Multiple Sclerosis
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other _____

Psychiatric Disorders

____ Depression
____ Frequent crying
____ Trouble sleeping
____ Other _____

Your GYN History

Menopause age :_____
Age of 1st period:_____
Cycle length: ☐28-days, ☐ 26-days,_____
Description: ☐ Clots ☐ Cramps ☐ Heavy
Tampons ☐ Pads: ☐ Both: ☐
Duration of period:_____days
LMP: _____ Depo: ☐ IUD: ☐

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Previous Pregnancies (List all previous pregnancies, include miscarriages or abortions)

	Date of Delivery	Length of pregnancy	Type of Delivery (Ex. Vag, C/S)	Sex (circle)	Baby's Weight	Delivering Doctor	Complications
1				M F			
2				M F			
3				M F			
4				M F			
5				M F			
6				M F			
7				M F			
8				M F			
9				M F			

PAST SURGICAL HISTORY:
Please list any surgeries and the date:

☐ Appendectomy _____ ☐ Cesarean section_____ ☐ Cholecystectomy_____ (gallbladder) ☐ D&C _____

☐ Hysterectomy_____ ☐ LEEP _____ ☐ Tubal ligation _____ ☐ Tonsillectomy _____

☐ Other _____

MEDICAL ALLERGIES: ☐ **None** If yes, please specify medications and reactions below

DRUG	REACTION
☐ Penicillin (s)	
☐ Cephalosporin (s)	
☐ Sulfa Drugs	
☐ Cipro	
☐ Latex	
☐ Other	

OTHER ALLERGIES: ☐ **None** If yes, please specify type and reactions below

TYPE	REACTION

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Medications: ☐ None

Are You on Any type of birth control? ☐ Yes ☐ No If yes please list the name of the birth control you are taking

_____

List any medications that you are currently taking (including supplements, vitamins, herbs or over-the-counter drugs)?

Drug	Strength	Dose	Frequency	Reason for Taking
Ex.: Lisinopril	10 mg	1 tab	Once a day	High blood pressure

Family History:
(Please check the ones that apply to you and list the relation to you)

☐ Stroke - Relation_____ ☐ Diabetes - Relation_____

☐ Heart Disease - Relation_____ ☐ High Blood Pressure - Relation_____

☐ Heart Attack - Relation_____ ☐Thyroid Disease - Relation_____

☐ Cancer - Relation_____ ☐ Other _____

Type of cancer:_____

Social History:

Tobacco Use: ☐ Never ☐ Former smoker ☐ Smoker: If smoker, quantity:_____

Alcohol Use: ☐ No ☐ Yes Number of drinks per week: _____

Number of drinks per occasion: _____

Illicit Drug use: ☐ No ☐ Yes

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic or Latin ☐ Not Latino or Hispanic ☐ Unreported / Refused to Report

Race: _____ Religion: _____ Occupation: _____

Health Maintenance (Date of last)

☐ Pap Smear: _____ ☐ Mammogram _____ ☐ Colonoscopy_____

☐ Bone Density Scan _____ ☐ Flu Vaccine _____ ☐Tetanus _____

☐ Pneumonia Vaccine _____ ☐ Gardasil 1st _____ 2nd _____ 3rd _____

I am here for the following:

☐ Follow up – Medications ☐ Follow up – Blood Pressure ☐ Follow up – Test Results

☐ Follow up – Gyn Problem ☐ Repeat Pap smear ☐ Colposcopy

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Patient Questionnaire **Name:**_____

Date:_____

Review of Systems

Please check (☑) if you are **CURRENTLY** having any of these symptoms

1. General		**8. Female Genitourinary**	
Weight Loss	❑	Blood in urine	❑
Weight Gain	❑	Painful urination	❑
Fever	❑	Urgency	❑
Fatigue	❑	Frequency of urination	❑
		Incomplete emptying	❑
		Involuntary leakage of urine	❑
		Abnormal periods	❑
		Painful intercourse	❑
		Vaginal Discharge	❑
2. Eyes		**9. Musculoskeletal**	
Double Vision	❑	Muscle weakness	❑
Spots before eyes	❑		
Vision Changes	❑		
3. Ears/Nose/Throat/Mouth		**10. Neurological**	
Earaches	❑	Dizziness	❑
Ringing in ears	❑	Seizures	❑
Sinus problems	❑	Numbness	❑
Sore throat	❑	Trouble walking	❑
Mouth sores	❑		
Dental problems	❑		
4. Respiratory		**11. Psychiatric**	
Wheezing	❑	Depression	❑
Spitting up blood	❑	Frequent crying	❑
Shortness of breath	❑		
Chronic cough	❑		
5. Skin/Breast		**12. Endocrine**	
Pain in breast	❑	Dry Skin	❑
Nipple discharge	❑	Abnormal thirst	❑
Masses	❑	Hot flashes	❑
Rash	❑		
Ulcers	❑		
6. Cardiovascular		**13. Hematologic/lymphatic**	
Painful breathing	❑	Frequent bruises	❑
Chest pain	❑	Cuts don't stop bleeding	❑
Difficulty breathing on exertion	❑	Enlarged lymph nodes	❑
Swelling of leg	❑		
Palpitations of heart	❑		
7. Gastrointestinal			
Frequent diarrhea	❑		
Bloody stool	❑		
Nausea	❑		
Vomiting	❑		
Constipation	❑		

June 19, 2013