

Patient Questionnaire

Name:		
Date:		

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

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) Congestive Heart Failure Coronary Artery Disease CYA (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) Cother Cother Cronditions Irritable Bowel Syndrome Other Kidney Bladder Problem Kidney Bladder Problem Stress Incontinence Frequent Urinary Infections Blood (Hematological) Disorders Anemia Bleeding Disorder Clotting Disorder Clotting Disorder Clotting Disorder Sickle Cell Disease Thalassemia Other Musculoskeletal Disorders Arthritis or Joint Pain Arthritis, Rheumatoid Fibromyalgia Osteoporosis Scollosis Osteoporosis Scollosis Osteoporosis Scollosis Other Neurological Disorders Multiple Sclerosis Seizure Disorders Seizure Disorders Psychiatric Disorders Psychiatric Disorders Psychiatric Disorders Trouble sleeping Other	Breast Conditions	Immune System Diseases
Breast Implants	Abnormal Mammogram	Chronic Fatigue Syndrome
Fibrocystic Breasts Other 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 Cancer Pelvic Inflammatory Disease (PID) Polvycystic Ovarian Syndrome (PCOS) Sexually Transmitted Disease Gonorrhea Chlamydia Herpes Trichomonas Vaginal Cancer (Neoplasm) Vulvar Cancer (Neoplasm) Vulvar Cancer (Neoplasm) Wulvar Cancer (Neoplasm) Cother Heart or Circulation Conditions (Cardiovascular) Corgenital Heart Disease Congestive Heart Failure Coronary Artery Disease CYA (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) Other Colitis, Ulcerative Corloit, Ulcerative Coron's Disease Hepatitis Irritable Bowel Syndrome Other Kidney Bladder Problem Cirtuhatios Hepatitis Irritable Bowel Syndrome Other Kidney Bladder Problem Stidney Bladder Problem Lepatitis Irritable Bowel Syndrome Other Kidney Bladder Problem Stidney Bladder Problem Lepatitis Irritable Bowel Syndrome Other Kidney Bladder Problem Stidney Bladder Problem Lepatitis Irritable Bowel Syndrome Other Midepatitis Irritable Bowel Syndrome Other Midney Bladder Problem Lepatitis Irritable Bowel Syndrome Other Midney Bladder Problem Midney Bladder Problem Lepatitis Irritable Bowel Syndrome Other Musculoskelata Disorders Musculoskelata Disorders Musculoskelata Disorders Musculoskelata Disorders Musculoskelatal Disorders Neurological Disorders Musculoskelatal Disorders Other Musculoskelata	Breast Cancer Left Right	Systemic Lupus Erythematosis
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Sexually Transmitted Disease		
Gonorrhea		Thalassemia
Herpes		
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EczemaOsteoporosisScoliosisOtherOtherOtherOther		Osteopenia
MolesOther		
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Congestive Heart Disease		
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CVA (Stroke) TIA or Stroke Hypertension (High Blood Pressure) Other Irregular Heart Beat Psychiatric Disorders Mitral Valve Disorders (MVP) Depression Asthma Frequent crying Pulmonary Embolism (Blood Clot - Lung) Trouble sleeping Thrombophlebitis (Blood Clot in arms or legs) Other	Coronary Artery Disease	Seizure Disorder (Epilepsy)
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Irregular Heart Beat Psychiatric Disorders Mitral Valve Disorders (MVP) Depression Asthma Frequent crying Pulmonary Embolism (Blood Clot - Lung) Trouble sleeping Thrombophlebitis (Blood Clot in arms or legs) Other		Other
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Pulmonary Embolism (Blood Clot - Lung) Trouble sleeping Thrombophlebitis (Blood Clot in arms or legs) Other		Frequent crying
Thrombophlebitis (Blood Clot in arms or legs) Other		Trouble sleeping
		Other
Endocrine (Glandular) Disorders Your GYN History	Endocrine (Glandular) Disorders	Your GYN History
Diabetes – Type I (Insulin-Dependent) Menopause age :	,	Menopause age :
Diabetes – Type II Age of 1 st period:		Age of 1 st period:
Pituitary Gland Disorder Cycle length: 28-days, 26-days,		
Thyroid Disease Description: Clots Cramps Heavy		
Other Tampons \square Pads: \square Both: \square	 ;	
Duration of period: days		·
LMP: Depo: □ IUD: □		



Patient Questionnaire Nam

Name:		
Date:		

Previous Pregnancies	(List all	previous	pregnancies.	include	miscarriages	or abortions)
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	Date of	Length of	Type of Delivery	Sex	Baby's	Delivering	
	Delivery	pregnancy	(Ex. Vag, C/S)	(circle)	Weight	Doctor	Complications
1	,	,	(3, 2, 2,	M F	<u> </u>		·
2				M F			
3				M F			
4				M F			
5				M F			
6				M F			
7				M F			
8				M F			
9				M F			
		ı	ı			I	

9				M F			
		L HISTORY: urgeries and th	e date:				
□Ар	pendectomy		Cesarean section	1		ctomy	□ D&C
□ Ну	sterectomy	D.	EEP	☐ Tubal	(gallbladde ligation	,	sillectomy
□ Ot	her						
MED	ICAL ALLE	RGIES:	□ N	one If yes	s, please speci	fy medications ar	nd reactions below
	DRU	JG		REA	ACTION		
	☐ Penicillin	(s)					
	☐ Cephalos	porin (s)					
	☐ Sulfa Dru	gs					
	☐ Cipro						
	☐ Latex					_	
	☐ Other						
отн	ER ALLERG	SIES: 🗆 Noi	пе	If yes,	please specify	type and reaction	ns below
		TYPE			R	REACTION	



I am here for the following: ☐ Follow up – Medications

☐ Follow up – Gyn Problem

Umter OB-GYN		Patient Qu	estionnaire	Name:
				Date:
Medications:	□ None			
Are You on Any typ	e of birth contro	o1? □ Yes □ N	o If yes please list	the name of the birth control you are taking
List any medication counter drugs)?	s that you are cu	ırrently takin	g (including supple	ements, vitamins, herbs or over-the-
Drug	Strength	Dose F	requency	Reason for Taking
Ex.: Lisinopril	10 mg	1 tab	Once a day	High blood pressure
Family History: (Please check the or		•	•	
☐ Stroke - Relation	n		☐ Diabetes -	Relation
☐ Heart Disease -	Relation		☐ High Blood	Pressure - Relation
☐ Heart Attack - Relation			□Thyroid Dis	ease - Relation
☐ Cancer - Relation	on		☐ Other	

Tobacco Use:	□ Never	☐ Form	ier smoker 🔲 Smoker: If sm	oker, quantity:
Alcohol Use:	□ No	☐ Yes	Number of drinks per week: _	
			Number of drinks per occasio	n:
Illicit Drug use:	□ No	☐ Yes	·	
Relationship	Status: 🗆	Single	☐ Married ☐ Separated	☐ Divorced ☐ Widowed
Ethnicity: 🗆 His	spanic or La	tin 🗆 No	ot Latino or Hispanic 🛛 Ur	reported / Refused to Report
Race:	Relig	gion:	Occupation:	
Race: Health Mainte			Occupation:	
	enance (Dat	te of last)	Occupation:	☐ Colonoscopy
Health Mainte	enance (Dat	te of last)		
Health Mainte ☐ Pap Smear: _	enance (Dat	e of last)	☐ Mammogram	☐ Colonoscopy

☐ Follow up – Test Results

☐ Colposcopy

☐ Follow up – Blood Pressure

☐ Repeat Pap smear



Patient Questionnaire

Name:	
Date:	

Review of Systems

	Please check (☑) if you are CURRENTLY having any of these symptoms								
1.	General Weight Loss Weight Gain Fever Fatigue	0000	8. Female Genitourinary Blood in urine Painful urination Urgency Frequency of urination Incomplete emptying Involuntary leakage of urine Abnormal periods Painful intercourse Vaginal Discharge						
2.	Eyes Double Vision Spots before eyes Vision Changes		9. Musculoskeletal Muscle weakness						
3.	Ears/Nose/Throat/Mouth Earaches Ringing in ears Sinus problems Sore throat Mouth sores Dental problems	00000	10. Neurological Dizziness Seizures Numbness Trouble walking						
4.	Respiratory Wheezing Spitting up blood Shortness of breath Chronic cough		11. Psychiatric Depression Frequent crying						
5.	Skin/Breast Pain in breast Nipple discharge Masses Rash Ulcers		12. Endocrine Dry Skin Abnormal thirst Hot flashes						
6.	Cardiovascular Painful breathing Chest pain Difficulty breathing on exertion Swelling of leg Palpitations of heart		13. Hematologic/lymphatic Frequent bruises Cuts don't stop bleeding Enlarged lymph nodes						
7.	Gastrointestinal Frequent diarrhea Bloody stool Nausea Vomiting Constipation	0000							

June 19, 2013