Northeast OB/GYN Health History Questionnaire

DATE: ___/____/_____

NAME: _____AGE: _____ DATE OF BIRTH: ____/____/_____

PRIMARY CARE DOCTOR: _____

Reason for visit? Is there anything in particular you would like to address with your physician today?

_____

_____

Subject to the needs of your health, a scheduled appointment may be changed by the provider to a different type of appointment *

GYN HISTORY

Age of first menstrual period? _____ Date of last menstrual period? _____ Age of menopause? _____

Are your menstrual cycles: ☐ Regular ☐ Irregular Every _____ days, lasting _____ days

Are you sexually active? ☐Yes ☐Not Currently ☐Never Number of lifetime partners _____

Current Partner: ☐ Male ☐ Female Length of relationship _____

Currently trying to get pregnant? ☐Yes ☐No

Current method of birth control?

☐ Pill	☐Patch	☐NuvaRing	☐Condoms/ Barrier Method	☐ Fertility Awareness
☐ Withdrawal	☐Depo Provera	☐Nexplanon	☐ Mirena/ Kyleena/ Liletta IUD	☐Paragard IUD
☐Tubal Ligation	☐Vasectomy	☐ None	☐ Essure	☐Other:_____

_____

Issues with birth control: _____

Date of last PAP smear: _____ (approximate if necessary)

Have you ever had an abnormal PAP smear? ☐Yes ☐No Approximately when? _____

Have you ever been diagnosed with HPV? ☐ Yes ☐No Have you had an HPV Vaccine? ☐ Yes ☐No

Have you ever had any of the following treatments of abnormal PAP smears (check all that apply):

☐ Colposcopy (year): _____ ☐LEEP (year): _____ ☐Cone Biopsy (year): _____

☐ Cryotherapy (year): _____ ☐ Laser (year): _____

Have you ever been treated for (check all that apply):

☐ Chlamydia ☐Gonorrhea ☐ Genital Wart ☐Herpes ☐ Trichomonas ☐Syphilis ☐Hepatitis C

Have you ever tested positive for HIV? ☐Yes ☐No Any past IV drug usage? ☐ Yes ☐ No

If applicable, when was your last mammogram? _____ (year) Last bone density _____ (year)

Last colonoscopy? _____(year) Last time you had blood work? _____ (year)

Have you ever had a breast biopsy? ☐No ☐Yes- Year: _____ Result: _____

GYN Review of Systems: Please check any that apply to you <u>at this time</u>. Do you currently have:

☐ Heavy periods	☐ Painful periods	☐Irregular periods	☐ Painful intercourse	☐ Pelvic pain
☐Vaginal irritation	☐ Vaginal discharge	☐ STD concerns	☐ Urinary incontinence	☐ Urinary pain
☐ Hot flashes	☐ Insomnia	☐ Weight change >10 lbs	☐ Vaginal Dryness	☐ Mood Swings
☐ Breast lump	☐ Breast pain	☐ Nipple discharge	☐ Fertility concerns	☐ Other_____

OB History

	#		#		#
Total Times Pregnant		Deliveries over 37 weeks		Deliveries before 37 weeks	
Miscarriages		Elective Abortions		Living Children	
Forceps or Vacuums		Ectopic Pregnancies		C-Sections	

Preg. #	Month/Year	Weight	Sex	Delivery (C-Sec, vaginal)	Complications
1.					
2.					
3.					
4.					
5.					
Please describe any pregnancy problems or complications below (ex: twins, gestational diabetes, stillbirth, etc.)					

Medical History: Do you now or have you ever had:

☐ Asthma	☐ Diabetes Type I	☐ Infertility	☐ Seizures	☐ Lupus
☐ Anxiety	☐ Diabetes Type II	☐ Interstitial Cystitis	☐ Sleep Apnea	☐ Stroke
☐ Autoimmune disorder	☐ Elevated Cholesterol	☐ Irritable Bowel Syndrome	☐ Neurologic Disorder	☐ Guillan Barre Syndrome
☐ Anemia	☐ Endometriosis	☐ High Blood Pressure	☐ Tuberculosis	☐ Kidney Stones
☐ Bleeding Disorder	☐ Fibroids	☐ Hyperthyroidism	☐ Genetic Disease	☐ Kidney Disease
☐ Blood Transfusion	☐ GERD/ Reflux	☐ Hypothyroidism	☐ Joint Disease	☐ Diverticulitis
☐ Chicken Pox	☐ Heart Disease	☐ Liver Disease	☐ Migraines	☐ Osteopenia
☐ DVT/ PE	☐ Hepatitis A or B	☐ Osteoporosis	☐ Depression	

☐ Cancer (Year/ Type/ Treatment):

☐ Other (Please Describe):

Medications and Supplements (Attach additional form if necessary)

Drug Name	Dosage	Drug Name	Dosage

Allergies: Please list medication/ substance and reaction

Hospitalizations/ Operations: Please list ALL hospitalizations or operations you've had:

	Year/ Month	Procedure/ Illness
1.		
2.		
3.		
4.		

Social History/ Personal Safety

Occupation: _____

Are you: ☐ Single ☐ Significant Other ☐Engaged ☐Married ☐Divorced ☐Widowed

Tobacco Use: ☐ Never ☐ Current _____ # cigarettes/day ☐Former, quit at age _____

Vaping Use: ☐ Never ☐ Current _____ # times/day ☐Former, quit at age _____

Any alcohol use? ☐No ☐Former ☐Yes, average # drinks/week _____

Any caffeinated drinks? ☐ No ☐ Yes: average cups/day: _____

Do you use any other drugs? ☐No ☐Former ☐Yes, type and last use _____

How many days/ week do you exercise? _____days/week, average hours/week _____

Do you have any cultural or religious considerations that we should be aware of? _____

Do you consistently wear seatbelts? ☐ Yes ☐No

Has anyone close to you in your past ever threatened your personal safety? ☐ Yes ☐No

Has anyone, including your current partner, ever forced you have sex? ☐ Yes ☐No

Do you currently feel physically, emotionally or verbally threatened by anyone in your life? ☐ Yes ☐No

Family History: Does anyone in your immediate family have:

☐ No ☐ Yes Breast Cancer If yes, what relation? _____

☐ No ☐ Yes Ovarian Cancer If yes, what relation? _____

☐ No ☐ Yes Colon Cancer If yes, what relation? _____

☐ No ☐ Yes Bleeding Disorder If yes, what relation? _____

☐ No ☐ Yes Heart Attack If yes, what relation? _____

☐ No ☐ Yes Osteoporosis If yes, what relation? _____

☐ No ☐ Yes Thyroid Disease If yes, what relation? _____

☐Other (or if you do not know your family's history): _____