PATIENT HISTORY QUESTIONNAIRE

PatientName:_____

DOB:_____

MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

1. Age at first period:_____years
2. If your menstrual periods are regular; periods start every:_____days
3. If your menstrual periods are irregular; periods start every:_____to_____days
4. Duration of bleeding:_____days.
5. Does bleeding or spotting occur between periods? Yes No
6. Does bleeding or spotting occur afteri ntercourse? Yes No

7. First day of last menstrual period: month_____day___year_____

8. Is pain associated with periods?_____Yes ___No _____

Occasionally If yes,is it:_____before menses _____during menses_____both

PREGNANCY HISTORY (All pregnancies)

Have never been pregnant

☐ OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL)PREGNANCIES

Year	Place of delivery	Gest.Age	Hrs.ofLabor	Type ofDelivery	ComplicationsMother and/orInfant	Sex	Birth Weight

CURRENTMEDICATIONS (Include dose (amount)per day)

Medication	Dose	Frequency

SEXUAL HISTORY

1. Do you have a sexual partner? ☐ No ☐ Yes (☐ Male ☐ Female)
2. Are there concerns about your sexual activity, which you may want to discuss with your doctor? ☐ Yes ☐ No

PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

1.Check any that apply: or ☐None

☐D&C	Yr._____	☐ovarian surgery	Yr._____
☐hysteroscopy	Yr._____	☐L cyst removed ovarian	Yr._____
☐infertility surgery	Yr._____	☐L cyst removed ovarian	Yr._____
☐tuboplasty	Yr._____	☐L ovarian removed	Yr._____
☐tubal ligation	Yr._____	☐R ovarian removed	Yr._____
☐laparoscopy	Yr._____	☐Vaginal/ bladder repair	Yr._____
☐hysterectomy (vaginal)	Yr._____	☐Cesarean Section	Yr._____
☐hysterectomy (abdominal)	Yr._____	☐Other	Yr._____
☐myomectomy	Yr._____		

PAST SURGICAL HISTORY (Not OB/GYN)

List all surgeries and their year or ☐None Surgeries

Surgeries	Year
_____	_____
_____	_____
_____	_____
_____	_____

PAP SMEAR/MAMMOGRAM HISTORY

Date of last Pap smear: _____

Have you had abnormal pap smears ☐No ☐Yes

Have you had treatment for abnormal smears ☐No ☐Yes

If yes, what type(s) of treatment have you had?

☐ Cryotherapy ☐Lasercone ☐Biopsy ☐Loop excision ☐Leep

Date of last mammogram: month _____ year_____

Have you had an abnormal mammogram ☐No ☐Yes_____

OTHER PAST GYNECOLOGICAL HISTORY

Check any that apply: ☐None ☐Venereal warts ☐Herpes(genital)

☐Syphilis ☐Pelvic inflammatory disease ☐Endometriosis ☐ Chlamydia

☐Gonorrhea ☐Vaginal infections ☐Other _____

PAST MEDICAL HISTORY

Check any that apply or ☐NONE

☐Arthritis
☐Diabetes
☐Diet Controlled
☐Pill Controlled
☐Insulin Controlled
☐High Blood Pressure
☐Thyroid Disease
☐Kidney Disease
☐Gallstones
☐Liver Disease (including hepatitis)
☐Epilepsy
☐Blood Transfusion
☐Other_____
☐Asthma
☐Emphysema
☐Bronchitis
☐HIV+
☐Eating Disorder
☐Heart Disease

CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

DO YOU CURRENTLY:

Smoke ☐No ☐Yes _____ packs/day
Use alcohol ☐No ☐Yes __ wine (glasses/day); __ beer (bottles/day); __ hard liquid (oz./day)
Use illicit drugs ☐No ☐Yes_____
31. Exercise:

DRUG ALLERGIES

☐Yes ☐No
List: _____
_____
_____

LIFE STYLE

Cats	☐No	☐Yes
Eating Problems	☐No	☐Yes
Exercise/Leisure	☐No	☐Yes
Hot Tub	☐No	☐Yes
Occupational Exposure	☐No	☐Yes
Physical/Sexual Abuse	☐No	☐Yes
Planned Pregnancy	☐No	☐Yes
Travel/Commute	☐No	☐Yes
Work	☐No	☐Yes

Other _____

FAMILY HISTORY

☐Diabetes ☐Heart Disease ☐Ovarian Cancer ☐Endometrial Cancer
☐Breast Cancer ☐Colon Cancer ☐None of the above

If "yes" to any, please list affected relatives

_____
_____
_____
_____

OTHER SYMPTOMS

Have you had recent:

☐ weight loss ☐weight gain ☐ change in energy ☐ change in exercise tolerance ☐hair growth ☐hair loss ☐change in urinary function ☐hot flushes/flashing ☐ breast discharge ☐ none of the above ☐other_____

Have you or the baby's father or anyone in your families ever had any of the following:

☐ Down syndrome ☐ NO ☐Yes_____
☐Other Chromosomal abnormality ☐ NO ☐Yes_____
☐Neural tube defect (spina bifida, anencephaly) ☐ NO ☐Yes_____
☐Hemophilia or other coagulation abnormality? ☐ NO Yes_____
☐Muscular Dystrophy ☐ NO ☐Yes_____
☐Cystic Fibrosis ☐ NO ☐Yes_____

If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease ☐ NO ☐Yes
☐Father Result _____
☐Mother Result _____

If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait ☐ NO ☐Yes
☐Father Result _____
☐Mother Result _____

If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? ☐ NO ☐Yes
☐Father Result _____
☐Mother Result _____

If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalassemia? ☐ NO ☐Yes
☐Father Result _____
☐Mother Result _____

PATIENT SIGNATURE_____Date_____