

Name _____

Date of Birth _____

Please take a few moments to complete this questionnaire so that we can provide the best medical care to you.

What is the reason for your appointment?

- Yearly check-up / Pap smear Other: _____

What questions do you have for your health care provider? _____

What prescription refills do you need from our office? _____

Do you use a mail order pharmacy? _____ What pharmacy do you use? _____

Please check if YOU are being treated or have been treated for any of the following:

- Anxiety Arthritis Asthma Blood Clots Breast Cancer COPD Heart Disease Colon Cancer
 Depression Diverticulitis Diabetes Reflux / GERD Cholesterol High Blood Pressure Migraines
 Irritable Bowel Low Thyroid Osteoporosis Seizures Stroke MRSA
 Other: _____

Please check if YOU have had had any of these surgeries or treatments.

- Appendectomy Bladder Repair Breast Surgery Heart Surgery Heart Stent D + C Tubal Ligation Hysterectomy
 Laparoscopy Gall Bladder C-Section Uterine Ablation Ovaries Removed- If so, Both Left Right Don't Know
 Other: _____

Please tell us about your pregnancies:

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of children living _____

Type of Contraception Use: _____

Has your partner had a vasectomy? Yes No

Please check if YOU are being treated or have been treated for any of the following:

- Treatment for Abnormal Pap Colposcopy LEEP Cryo (Freezing) Endometriosis Ovarian Cancer Uterine Cancer
 Pelvic Pain Infertility Irregular Periods Polycystic Ovaries Ovarian Cysts Herpes Gonorrhea
 Chlamydia Genital Warts Other: _____

OB/GYN CARE

Please check if anyone in **Your Family** has or had any of the following.

- Blood Clots
 Breast Cancer (who _____)
 Ovarian Cancer (who _____)
 Uterine Cancer
 Colon Cancer
 Other: _____

Social History

Are you? Single Married Divorced Widowed Separated

- Do you smoke? Cigarettes e-cig Vape No Quit _____ Packs a Day
 Drink Alcohol None Occasionally Daily How Much _____
 Drug Use None Yes- List Drug Used: _____

Are you sexually active: Yes _____ No _____ Partners: Male _____ Female _____ Both _____

Have you had the Gardasil vaccine? Yes No If yes, how many doses? 1 2 3

What medicines are you allergic to? _____

What medicine are you taking – both prescribed and over the counter (or attach list):

Do you feel safe in your relationship? Yes No

- If no: Do you have a safe place to go: Yes No
 Are there guns in your house: Yes No
 Do you have a PFA issued: Yes No
 Counseling given: Yes No

Other: _____

Please answer the following questions regarding

1.) Contraception- Skip to number 2 if you have had a hysterectomy, your tubes tied, or are in menopause.

a.) What is your current form of birth control? _____

b.) How long have you been using your current form of birth control? (Please check one)

- 2 years or less
 3-5 years
 6-10 years
 Over 10 years

c.) When are you planning to have another child? (Please check one)

- Within the next year
 Within the next 5 years
 Within the next 10 years
 My family is complete

2.) Menstrual Periods-Skip to number 3 if you have had a hysterectomy or in menopause.

Date of your last menstrual period _____ / _____ / _____
Month Date Year

- a.) How long does your average monthly period last? _____ Days.
- b.) Do you ever feel as though your periods impact the quality of your life? Yes No
- c.) Do you ever experience irregular or inconsistent bleeding patterns? Yes No
- d.) Would you like information on a simple, safe procedure to significantly reduce or eliminate your monthly periods? Yes No

3.) Breast Health

- a.) Are you experiencing any breast lumps, discharge, or pain? Yes No

4.) Urinary Health

- a.) Do you ever leak urine when you cough, laugh, sneeze, or with activity? Yes No
- b.) Do you ever feel as though you have to urinate urgently or leak urine with this urgent sensation? Yes No
- c.) Do you feel like you have to urinate too frequently or get up frequently at night to urinate? Yes No
- d.) Do you ever experience painful urination or blood in your urine? Yes No
- e.) Have you had evaluation or treatment for these symptoms in the past? Yes No
- If yes, How? Urodynamic Medications Surgery

5.) Genital Tract

- a.) Are you experiencing abnormal vaginal discharge? Yes No
- b.) Are you experiencing pelvic pain? Yes No
- If yes, where? _____
- c.) Are you experiencing painful intercourse or bleeding after intercourse? Yes No

6.) Gastrointestinal Health

- a.) Are you experiencing nausea or vomiting? Yes No
- b.) Are you experiencing diarrhea, constipation or change in bowel movements? Yes No
- c.) Are you experiencing rectal bleeding? Yes No
- d.) Are you experiencing change in appetite, bloating or abdominal pain? Yes No

7.) General Health

- a.) Have you had an unexpected weight gain or loss? Yes No
- b.) Are you experiencing fever or chills? Yes No
- c.) If you are under 26 years of age, have you had the HPV vaccine? Yes No
- d.) Are you at risk for osteoporosis (loss of height, family hx, and menopause)? Yes No

OB/GYN CARE

e.) Do you feel safe at home and at work?

Yes No

f.) Any other concerns or questions? _____

Please check the following if you are experiencing any of these symptoms

8.) ENT/Mouth

Ulcers Sinusitis Tinnitus Headaches / Migraines

9.) Cardiovascular

Shortness of breath Chest pain Edema Palpitations

10.) Respiratory

Wheezing Shortness of breath Cough

11.) Musculoskeletal

Muscle weakness

12.) Neurological

Fainting / blackouts Seizures Numbness Difficulty walking

13.) Hema/Lymph

Bruising Bleeding Swollen lymph glands

Please list the dates of your last exam as listed below. Please list the year.

Pap smear _____

Mammogram (if over 40 years old) _____

Colonoscopy (if over 50 years old) _____

Bone Density (if in menopause) _____

Cholesterol check (if over 45 years old) _____

Who is your primary care doctor? _____

Who referred you to our practice? _____

Thank you for taking the time to fill out this questionnaire. This will allow us to better take care of you and ensure that we have addressed the issues that are important to you. This will not become part of your permanent record.