WASHINGTON HEALTH SYSTEM
Washington Physicians Group

OB/GYN CARE

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 <u>YOU</u> 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 <u>YOU</u> 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 <u>YOU</u> 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: _____

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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

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.