Pacific Obstetrics & Gynecology

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HEALTH QUESTIONNAIRE

Name ______________________________ Date ____________________

Date of Birth ______________ Age ________ Referred by ______________________________

Reason for Visit ____

Obstetrical History

How many times have you been pregnant? __________ Number of vaginal deliveries ____________

Number of cesareans ________ Reason for cesareans ______________________________

Number of miscarriages ________ Number of ectopic pregnancies/treatment ________________

Number of elective abortions ________ Premature births ________ Stillbirths ______________

Number of living children ________ Adopted children ________ Weight of largest infant __________

Any complications during your pregnancy? ______________________________________

Do you wish for more pregnancies? ____

Gynecologic History

Date of last menstrual period ______________________ Was it normal? Yes _____ No _____

Are you taking birth control pills? Yes ______ No ______ Type ______________________

Menstrual periods come every _________ days and last for _________ days.

Any recent changes in your periods? Yes ______ No ______ If yes, explain: ______________

____

Excessive pain with your periods? Yes ______ No ______

Excessive bleeding with your periods? Yes ______ No ______

Premenstrual symptoms (PMS)? Yes ______ No ______

If yes to any of the above, please explain: ______________________________________

Preventative Health

Date of last pap smear ______________________ Normal _________ Abnormal __________

Previous abnormal pap? Yes ______ No ______ If yes, please explain and date ______________

Date of last mammogram ______________________ Normal __________ Abnormal _________

Do you do self breast exams? Yes _______ No ________

Do you or have you had a breast lump? Yes _______ No ________

Do you have annual check-ups with a family doctor or internist? Yes _______ No ________

Date of last visit ________________ Name of physician ______________________________

Name ______________________________ Date ____________________

Sexuality

Are you sexually active? Yes _______ No _______

Do you have a need for birth control? Yes _______ No _______

Do you have pain with sexual relations? Yes _______ No _______

Do you have any questions regarding sexuality? Yes _______ No _______

Birth Control

Current method of contraception (circle one): Pill IUD Condoms Cervical cap
Diaphragm Depo-provera Implanon Tubal sterilization Vasectomy

Are you satisfied with this method? Yes _______ No _______

Other methods of contraception previously used ______________________________

Infections

Do you have recurrent vaginal infections? Yes _______ No _______

If yes, please explain: ______________________________

Have you ever had a sexually transmitted infection? Yes _______ No _______

If yes, please circle: Herpes Warts Chlamydia Gonorrhea Syphilis
Pelvic inflammatory disease Other ______________________________

How was it treated? ______________________________

Menopause

Have you stopped having periods? Yes _______ No _______

Have you had a hysterectomy? Yes _______ No _______

Surgical removal of ovaries? Yes _______ No _______

Do you take hormone replacement therapy? Yes _______ No _______
If yes, name and how taken? ______________________________

Have you had any recent vaginal bleeding? Yes _______ No ______ Date ____________

Do you have: Accidental loss of urine? ______ Vaginal dryness? ______ Pelvic pressure? ____
Hot flushes? _____ Pain with intercourse? _____

Past Medical History

Allergies to medications: ______________________________

Medications you are currently taking (including birth control pills):

1. ____________________ 3. ____________________ 5. ____________________

2. ____________________ 4. ____________________ 6. ____________________

Name ______________________________ Date ____________________

Surgeries: (List date, type, hospital, complications)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Medical Illnesses or Problems (please list):

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Have you had problems with any of the following conditions?

___ High blood pressure ___ Embolus ___ Asthma ___ Heart dz
___ Bladder infections ___ Diabetes ___ Seizures ___ Migraines
___ Thyroid disease ___ Hepatitis ___ Lung disease ___ Phlebitis
___ Kidney disease

Family History

Has any of your blood relatives had:

_____ High blood pressure _____ Diabetes _____ Colon cancer
_____ High cholesterol _____ Heart disease _____ Breast cancer
_____ Cervical cancer _____ Uterine cancer _____ Ovarian cancer

Are you adopted? Yes _____ No _____

Review of Systems

Do you have or have you ever had:

1. Problems with your eyes, ears, nose or throat? Yes _____ No _____
   Explain: ______________________________
2. Problems breathing or shortness of breath? Yes _____ No _____
   Explain: ______________________________
3. Problems with your heart, mitral valve prolapse, rheumatic fever, chest pain, irregular heart beat or abnormal electrocardiogram? Yes _____ No _____
   Explain: ______________________________
4. High blood pressure? Yes _____ No _____
   Explain: ______________________________
5. Problems with fibrocystic breasts, breast mass or nipple discharge? Yes _____ No _____
   Explain: ______________________________
6. Problems with your bowels, change in bowel habits, diarrhea, constipation, hemorrhoids or bleeding with bowel movements? Yes _____ No _____
   Explain: ______________________________

Name ____ Date ________________________________

7. Problems with urination, kidney/bladder infection or accidental loss of urine? Yes _____ No _____
   Explain: ____

8. Problems with pelvic pressure, low back pain or sensation of pelvic organs falling? Yes ___ No ____
   Explain: ____

9. Problems with excessive thirst, frequent urination, feeling extremely cold or lethargic? Yes ___ No __
   Explain: ____

10. Arthritis, thrombophlebitis, easy bruising or varicose veins? Yes _____ No _____
    Explain: ____

11. Change in voice or increased facial/body hair? Yes _____ No _____
    Explain: ____

12. Depression, anxiety or the need for psychological/psychiatric care? Yes _____ No _____
    Explain: ____

13. Have you used IV drugs, had a partner who was bisexual or used IV drugs or had more than ten sexual partners in your life? Yes _____ No _____

14. Have you had a weight change of more than 20 lbs. over the past year or a history of an eating disorder such as bulimia or anorexia nervosa? Yes _____ No _____
    Explain: ____

15. Problems with abdominal pain, bloating or indigestion? Yes _____ No _____
    Explain: ____

16. Have you had difficulty sleeping or night sweats? Yes _____ No _____
    Explain: ____

17. Have you ever had a blood transfusion? Yes (date) _____________ No _____

Social History

Do you smoke? _____ How much? ___________ For how long? _____ In the past? ________

Do you drink alcohol? ________ How much? __________ How often? ____________________________

Do you use drugs socially? ________ If yes, please specify and how often? ____________________________

Do you exercise? ________ Type of exercise and how often? ____

Last grade of school attended ________________Occupation ____

Optional

Have you been physically or mentally abused by your spouse, partner, other? Yes ____ No ____
Explain: ____

Have you been sexually abused or raped? Yes ____ No ____
Explain: ____

How many sexual partners have you had in your life? ____

What is your ethnicity? ____

Any other concerns or questions? ____

We appreciate the time and effort you have taken to complete this questionnaire. Thank you!