Oakdale OB/GYN

New GYN Patient Questionnaire (4 pages total, front and back)

Date__________________________ Date of Birth_________________

Legal Name: ____Preferred Name_________________________

Preferred form of Address: □She/Her □He/Him □They/Them □Other_______________________

Primary Care Physician: ____

What are your primary concerns today? ____

Do you have an advance directive? (a set of written instructions that specify what actions should be taken if you are no longer able to make decisions about your health care due to illness or incapacity) Yes No

MEDICAL HISTORY -Have you ever been diagnosed with any of the following conditions?		
Condition	Please check if "yes"	Please fill in date of diagnosis
Sexually transmitted infections		
Breast cancer		
Ovarian cancer		
Uterine /endometrial cancer		
Colon cancer		
Colon polyps		
Osteoporosis/Osteopenia		
Heart attack/Heart disease		
Stroke		
Clots in legs or lungs (DVT or pulmonary embolism)		
Diabetes		
Thyroid disease		
High blood pressure		
High cholesterol		
Depression or anxiety		

Other:

CURRENT MEDICATIONS - Prescription and over the counter medications including vitamins, and herbal supplements.			
Medication	Dose	Medication	Dose

ALLERGIES (food, medication, other)			
List allergy	List reaction	List allergy	List reaction

Please list all past surgeries			
Surgery	Date	Surgery	Date

OB HISTORY:

Total # of Pregnancies:___________

# Full Term Births (37wks+)	# Premature Births (<37wks)	# Abortions
#Miscarriages	#Tubal Pregnancies	#Living Children

Birth Date	Weeks Gestation	Baby's Weight	Baby's Sex	Type of Delivery	Location of Delivery	Complications? (examples: hemorrhage, high blood pressure, diabetes, bad tearing)

GYNECOLOGICAL HISTORY (If you are in menopause, what age did your periods stop? _______ You may skip the remainder of this section.)
Cycle Regular? Yes No Interval (number of days):
Flow: None Light Medium Heavy
How many days does your period last?
Do you bleed between periods? Yes No
Cramps: None Mild Moderate Severe
Date of last menstrual period:
Are you Sexually Active? Yes No (If No you may skip the next questions)
Partners: Male Female Both
Do you need of pregnancy prevention? Yes No Method of Birth Control?

SOCIAL HISTORY
Marital Status: Single Partnered Engaged Married Divorced Widowed
Your occupation Spouse/Partner Name
How much alcohol do you drink in a typical week?
Have you ever felt you ought to cut down on your drinking? Yes No
Have you ever had people annoy you by criticizing your drinking? Yes No
Have you ever felt bad or guilty about your drinking? Yes No
Have you ever had a drink first thing in the morning to steady your nerves, get rid of a hangover or to get the day started? Yes No
Do you smoke? Never Quit Yes How many per day?
Do you want help to quit? Yes No
How often do you exercise? None 1x week 1-3x week 4 or more x week
Do you always wear a seat belt? Yes No
Are you afraid of your spouse/partner/significant other/family member? Yes No
Would you like to be tested for sexually transmitted infections? Yes No

FAMILY MEDICAL HISTORY –Have any family member (parents, grandparents, aunts/uncles, siblings, children) ever been diagnosed with any of the following conditions?		
Condition	List family member with condition	Age of onset or diagnosis
Breast cancer		
Ovarian cancer		
Uterine /endometrial cancer		
Colon cancer		
Colon polyps		
Osteoporosis/Osteopenia		
Heart attack/Heart disease		
Stroke		
Clots in legs or lungs (DVT or pulmonary embolism)		
Diabetes		
Thyroid disease		
High blood pressure		
High cholesterol		
Depression		
Genetically linked disease (Cystic Fibrosis, etc)		

Other:

HEALTH MAINTENANCE AND SCREENING TESTS & WHEN THEY WERE LAST PERFORMED			
Pap Test Date:			
Any abnormal Pap results: Yes No			
If abnormal Pap result please list the YEAR of abnormal result:			
If abnormal Pap how was it treated?			
Mammogram	Date:	Any abnormal:	Yes No
Cholesterol	Date:	Normal	High
Diabetes Screening	Date:	Normal	High
Thyroid Screening	Date:	Normal	Abnormal
Colonoscopy	Date:	Any abnormal: Yes No	
Bone Density (DXA)	Date:	Any abnormal: Yes No	
How much calcium (servings or milligrams) do you get in a day?			
Hepatitis C Screening (recommended at least once for all people born in the years 1945-1965) Yes No			
Date of Tetanus vaccine			
Have you completed the Gardasil HPV vaccine series? Yes No			

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:	Not at all	Several Days	More Than Half the Days	Nearly Every Day
Feeling down, depressed or hopeless:	Not at all	Several Days	More Than Half the Days	Nearly Every Day

Patient Signature: ________________________________ Date: _________________

Clinician Signature: _______________________________