



Primary Care Gynecology and Obstetrics

Initial Patient Questionnaire

Name _____
 EC# _____
 DATE _____

DOB _____ AGE _____
 MARITAL STATUS – SM W D SP
 OCCUP _____
 EMPLOYER _____
 REFERRED BY _____

CURRENT PRIMARY CARE PHYSICIAN

NAME	SPECIALTY	CITY, STATE	APPROX DATE OF LAST VISIT

YOUR LAST OB/GYN PHYSICIAN

NAME	SPECIALTY	CITY, STATE	APPROX DATE OF LAST VISIT

PLEASE LIST OTHER PHYSICIANS YOU ARE CURRENTLY SEEING

NAME	SPECIALTY	CITY, STATE	APPROX DATE OF LAST VISIT

REASON FOR SEEING THE DOCTOR TODAY:

PHYSICIAN NOTES:



HOSPITALIZATION HISTORY

DATE	ILLNESS OR OPERATION	PHYSICIAN/HOSPITAL	COMPLICATIONS

PREGNANCY HISTORY

Total # pregnancies _____
 Total # term births _____
 Total # preterm _____
 Total # miscarriages _____
 Total # abortions _____
 Total # stillbirths _____
 Total # living children _____

DATE	WEEKS GESTATION	VAGINAL or C-SECTION	WEIGHT OF BABY	MALE or FEMALE	TYPE OF ANESTHESIA	HOURS LABOR	COMPLICATIONS

CONTRACEPTIVE HISTORY

Check all birth control methods you have used in the past, or are using now

	Current	Past	Complications
Natural Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spermicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Condoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depo Provera	<input type="checkbox"/>	<input type="checkbox"/>	_____
Norplant	<input type="checkbox"/>	<input type="checkbox"/>	_____
IUD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sterilization (either partner)	<input type="checkbox"/>	<input type="checkbox"/>	_____



GYNECOLOGICAL HISTORY

Age at first menstruation _____

First day of last period _____

If menopausal: _____

Age of menopause _____

Bleeding since _____

Interval between periods _____

(first day of menses to first day of next menses)

Length of period _____

(number of days of bleeding each month)

Usual number of pads/tampons _____

Used on heaviest day _____

Cramps none mild moderate severe

Medicine used for cramps _____

Date of last pap smear _____

normal abnormal

Date of last mammo _____

normal abnormal

	Yes	No	Explain
Are you currently sexually active	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been sexually active in the past year	<input type="checkbox"/>	<input type="checkbox"/>	_____
Number of sexual partners in past			_____
Total number of sexual partners in past			_____
Have you had, or do you have:			
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any pelvic infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pelvic inflammatory disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	_____
HPV or venereal warts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bacterial Vaginosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Yeast Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal pap smears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any exposure to DES	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had cancer of the Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uterus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had benign disease of the breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____



CURRENT GYNECOLOGICAL COMPLAINTS

Are you currently having	Yes	No	Explain
Vaginal itching or discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vulvar itching		<input type="checkbox"/>	_____
Pain with intercourse		<input type="checkbox"/>	_____
Bleeding after intercourse		<input type="checkbox"/>	_____
Pain between periods		<input type="checkbox"/>	_____
Bleeding between periods		<input type="checkbox"/>	_____
Frequent urination		<input type="checkbox"/>	_____
Pain with urination		<input type="checkbox"/>	_____
Excess urination at night		<input type="checkbox"/>	_____
Blood in the urine		<input type="checkbox"/>	_____
Leakage of urine		<input type="checkbox"/>	_____
Leakage of stool		<input type="checkbox"/>	_____
Prolapse of bladder, uterus, bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast lump		<input type="checkbox"/>	_____
Breast discharge		<input type="checkbox"/>	_____
Change in breasts		<input type="checkbox"/>	_____
Breast pain		<input type="checkbox"/>	_____

PAST MEDICAL HISTORY

Have you had	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems		<input type="checkbox"/>	_____
Neck surgery or irradiation		<input type="checkbox"/>	_____
Diabetes		<input type="checkbox"/>	_____
Wheezing or Asthma		<input type="checkbox"/>	_____
Tuberculosis		<input type="checkbox"/>	_____
Pneumonia		<input type="checkbox"/>	_____
Tobacco use		<input type="checkbox"/>	_____
Phlebitis or blood clots		<input type="checkbox"/>	_____
High blood pressure		<input type="checkbox"/>	_____
Heart Murmur		<input type="checkbox"/>	_____
Rheumatic fever or heart disease		<input type="checkbox"/>	_____
High cholesterol		<input type="checkbox"/>	_____
Ulcer disease		<input type="checkbox"/>	_____
Gallbladder disease		<input type="checkbox"/>	_____
Hepatitis or liver disease		<input type="checkbox"/>	_____
Colitis or irritable bowel syndrome		<input type="checkbox"/>	_____
Colon Cancer		<input type="checkbox"/>	_____
Kidney or bladder infections		<input type="checkbox"/>	_____
Kidney stones		<input type="checkbox"/>	_____
Skin cancer		<input type="checkbox"/>	_____
Seizures or epilepsy		<input type="checkbox"/>	_____
Stroke		<input type="checkbox"/>	_____
Head trauma		<input type="checkbox"/>	_____
Brain or spinal surgery		<input type="checkbox"/>	_____
Anemia		<input type="checkbox"/>	_____
Blood transfusion		<input type="checkbox"/>	_____
Sickle cell disease		<input type="checkbox"/>	_____
Lupus or arthritis		<input type="checkbox"/>	_____



ALLERGIES

MEDICATION	REACTION
OTHER ALLERGIES	

CURRENT MEDICATIONS

DRUG	DOSAGE	FREQUENCY

SOCIAL PROFILE

Education _____

Who currently lives in household _____

Health of your parents _____

Health of your children _____

Health of brothers and sisters _____

Anyone in family with Heart disease Breast cancer Sickle cell
 Diabetes Colon cancer Birth defects
 Arthritis Ovarian cancer Other cancer

	YES	NO
Do you live in a non-smoking household	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear seat belts	<input type="checkbox"/>	<input type="checkbox"/>
Do you practice breast self-exam	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly	<input type="checkbox"/>	<input type="checkbox"/> hrs/wk _____
Do you have regular dental and eye exams	<input type="checkbox"/>	<input type="checkbox"/>
Do you use sunblock	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any violent relationships	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been abused	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcoholic beverages	<input type="checkbox"/>	<input type="checkbox"/> #/wk
Do you use street drugs	<input type="checkbox"/>	<input type="checkbox"/>
Are there firearms in your home	<input type="checkbox"/>	<input type="checkbox"/>



CURRENT COMPLAINTS

Do you have problems with...	YES	NO	Explain
General			
Change in weight	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent night sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine			
Intolerance to heat or cold	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal hair growth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, Ears, Nose, Throat			
Visual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinning sensations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary			
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheezing or asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Current tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	_____
			If yes, # packs per day _____ # years _____
Cardiovascular			
Limited exercise tolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting episodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal			
Frequent nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Black or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin			
Itching or rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moles that are changing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic			
Headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness or weakness of limbs	<input type="checkbox"/>	<input type="checkbox"/>	_____



CURRENT COMPLAINTS (continued)

Musculoskeletal

Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____

Psychosocial

Problems with relationships	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping/nightmares	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work or family problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

IMMUNIZATIONS

VACCINE	LAST RECEIVED
Tetanus/diphtheria	
Influenza	
Rubella	
Hepatitis	
Pneumonia	
Chicken pox	