PATIENT HISTORY QUESTIONNAIRE

The information provided will become part of your medical record and is totally **confidential.** This information will assist us in our effort to provide quality health care.

Reason for Visit: _____

_____

Menstrual History

(skip to next section if you are post-menopausal)
Age of first period: _____
How often are your periods: _____
Length of menstrual period: _____
Date of last menstrual period: _____
Heavy flow: Y / N How many days: _____

Do you experience (check all that apply)
o Menstrual pains
o Vaginal Discharge
o Spotting/bleeding between periods

(skip if you are pre-menopausal)
Age of Menopause: _____
Have you been on Hormone Replacement Therapy? Y / N
Are you experiencing any vaginal bleeding? …. Y / N

Gynecological History

When was your last pap smear: _____
Have you had an abnormal pap smear? ……. Y / N
If yes, when was it and what treatment did you have? _____
Have you ever had gynecological surgery? ….. Y / N
Describe _____

_____
Date of your last mammogram: _____
Have you had an abnormal mammogram? …. Y / N

Check if you have any of the following:
o ovarian cyst o fibroid uterus o endometriosis
o infertility o incontinence o polycystic ovaries
o pelvic inflammatory disease
o pelvic organ prolapse o painful urination
o pain on passing stool with periods

Obstetrical History

Pregnancies _____
Live Births _____
How many were delivered vaginally _____
Episiotomy or Tears? _____
Forceps or Vacuum? _____
Weight of heaviest child at birth? _____
Have you experienced an ectopic pregnancy? Y / N

Sexual History

Are you sexually active? ……..Y / N
If yes, with men / women / both
Do you use birth control? ……..Y / N
If yes, what? _____

_____
# of sexual partners in the last year? _____
Pain/discomfort during sex …….. Y / N
Bleeding/Spotting after sex …….. Y / N
Have you ever been diagnosed/treated for a sexually transmitted disease? …….. Y / N
If yes, when? _____

Urogyne

Do you experience?
o urine leakage when cough/sneezing
o urine leakage on urge to void
o unable to defer urinating
o difficulty emptying bowel or bladder
o awareness of bulge or pressure
o Constipation o Diarrhea o Bloating
How many times do you void at night _____
Amount of coffee/tea/pop per day _____
Are you using vaginal hormone cream …… Y / N
If yes, which one _____
Do you do heavy lifting over 13 lbs …… Y / N

Medical History

Do you have any major medical problems? …. Y / N

Please describe _____

_____

Have you ever had or been diagnosed with:

o Cancer o Heart disease o High blood pressure

o High cholesterol o Phlebitis/blood clots

o Pulmonary embolus o hepatitis/jaundice

o Irritable bowel o Colitis o Thyroid disease

o Diabetes o Anemia o HIV o Kidney problems

o Eating disorder o Seizures o Depression

o Alcoholism o Drug addiction

Do you smoke: Y / N How many per day _____

Notes:

Allergies:

_____

_____

Previous Surgeries:

_____

_____

_____

Current Medications:

_____

_____

_____

Family Medical History (**Cancer**, Diabetes, etc):

_____

_____

_____