GWINNETT OB/GYN ASSOCIATES, P.C.
Gynecology Questionnaire

NAME:_____ **DATE**:_____

DATE OF BIRTH:_____

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) _____

_____

PAST MEDICAL HISTORY:

List all operations you have had.

	OPERATION	DATE
A.		
B.		
C.		
D.		
E.		
F.		

List all illnesses you have had that required hospitalization.

	ILLNESS	DATE
A.		
B.		
C.		
D.		
E.		
F.		

Have you ever had? (Check yes or no and give dates.)

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	
( )	( )	Thyroid Disorder	
( )	( )	Pneumonia	
( )	( )	Tuberculosis	
( )	( )	Heart Murmur	
( )	( )	High Blood Pressure	
( )	( )	Rheumatic Fever	
( )	( )	Diabetes	
( )	( )	German Measles or Vaccine	
( )	( )	Anemia	
( )	( )	Convulsions or Seizures	
( )	( )	Ulcers	
( )	( )	I will accept blood products if necessary	

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	
( )	( )	Kidney Stones	
( )	( )	Kidney Infection	
( )	( )	Bladder Infection	
( )	( )	Genital Herpes	
( )	( )	Gonorrhea	
( )	( )	Syphilis	
( )	( )	Broken Bones	
( )	( )	Arthritis	
( )	( )	Mental Illness	
( )	( )	Serious Injury	
( )	( )	Blood Transfusion	

Please list any additional medical conditions or illnesses:

ILLNESS	DATE

REVIEW OF SYSTEMS:
Are you currently having or have you recently had any of these symptoms? (Check "**YES**" or "**NO**")

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Headaches
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest discomfort on exertion
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C. BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast cancer
( )	( )	Previous mammogram date _____

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E. GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Pain in legs when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

GWINNETT OB/GYN ASSOCIATES, P.C.

Gynecology Questionnaire (Sheet 2)

NAME: _____

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1._____ 3._____

2._____ 4._____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones) _____

_____

_____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT			
PREVIOUS			

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.					
2.					
3.					
4.					
5.					
6.					

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death.) _____

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?

_____

_____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? ❒ Yes No ❒ How many/day? _____ How many years? _____

Do you drink alcohol? ❒ Yes No ❒ How many drinks/day? _____ Per week? _____

Do you get any regular exercise? ❒ Yes No ❒ How often? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period: _____ Age first started period: _____ Usual number of days from one period to the next: _____

Usual # of days of flow: _____ Are your periods: Light ❒ Moderate ❒ Heavy Any excessive bleeding or spotting between cycles? ❒ Yes No ❒

Cramps with periods? ❒ Yes No ❒ Depression, anxiety, emotional upset before periods? ❒ Yes No ❒

PAP SMEARS:

Last pelvic exam: _____ Last pap smear: _____ Have you ever had an abnormal pap? ❒ Yes No ❒

If yes, what treatment was done? _____ Have your paps been normal since treatment? ❒ Yes No ❒

Did your mother take hormones while pregnant with you? ❒ Yes No ❒

VAGINITIS:

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____

Are you having any problem with discharge now? ❒ Yes No ❒

SEXUAL HISTORY:

Any problems with pain? ❒ Yes No ❒ Any problem with Orgasm? ❒ Yes No ❒ Other? _____

Any history of STDs? HPV ❒ Yes No ❒ Herpes ❒ Yes No ❒ Syphilis ❒ Yes No ❒ Hepatitis ❒ Yes No HIV ❒ Yes No ❒

Gonorrhea ❒ Yes No Chlamydia ❒ Yes No ❒ Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

_____

_____

_____

_____

_____