GYN QUESTIONAIRE

PATIENT NAME_____

REASON FOR VISIT_____

LAST MENSTRUAL PERIOD_____

HOW MANY TIMES HAVE YOU BEEN PREGNANT _____

HOW MANY LIVE BIRTHS_____

ARE YOU PLANNING TO BECOME PREGNANT_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING

PRESCRIPTIONS_____

NON-PRESCRIPTION_____

VITAMINS_____

HERBAL_____

ERGIES_____

SURGICAL HISTORY_____

FORM OF CONTRACEPTION_____ ANY SEXUAL ISSUES_____

LAST PAP SMEAR_____ ANY ABNORMAL PAP SMEARS_____

LAST MAMMOGRAM_____ ANY ABNORMAL MAMMOGRAMS_____

FAMILY HISTORY OF BREAST OR GYNECOLOGICAL CANCERS YES___ NO___

IF YES, WHAT TYPE OF CANCER_____

RELATIONSHIP_____

FAMILY HISTORY OF DIABETES YES____ NO____

HIGH BLOOD PRESSURE YES____ NO___ HIGH CHOLESTEROL YES___ NO___

HEART DISEASE YES____ NO___

ANY OTHER DISEASE YES____ NO___ IF YES, WHAT_____

SMOKER YES___ NO___ ALCOHOL YES___ NO___ DRUGS YES___ NO___

SEXUAL ABUSE YES___ NO___ IF YES, HOW LONG _____

DO YOU HAVE HEAVY PERIODS YES____ NO___

CYCLE LENGTH_____ DURATION_____

DO YOU HAVE HISTORY OF PELVIC PAIN YES____ NO___

DO YOU HAVE HISTORY OF ENDOMETRIOSIS YES___ NO___

DO YOU HAVE PAINFUL PERIODS EFFECTING YOUR LIFE YES___ NO___

ARE YOU HAVING URINARY PROBLEMS (PAIN, FREQUENCY, LEAKING, URGENCY) YES___ NO___

FAMILY OR PERSONAL HISTORY OF BLOOD CLOTS IN LEGS OR LUNGS YES___ NO___

LAST BONE DENSITY_____ PREVENTATIVE CARE_____