MICHIGAN
WOMEN'S HEALTH
A Division of Michigan Healthcare Professionals
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OBGYN QUESTIONNAIRE

Patient Name: First _____ MI _____ Last _____

Reason for visit _____

Last menstrual period _____

How many times have you been pregnant? ___ How many live births? ___ Are you planning on becoming pregnant? ___

What medications are you currently taking? _____

Prescriptions _____

Non-Prescription _____

Vitamins _____

Herbal _____

Allergies _____

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 ◯ If yes, what type? _____ No ◯

High blood pressure? Yes ◯ No ◯ High cholesterol? Yes ◯ No ◯ Heart disease? Yes ◯ No ◯

Any other disease? Yes ◯ No ◯ If yes, please explain: _____

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 any pelvic pain? Yes ◯ No ◯ Do you have history of endometriosis Yes ◯ No ◯

Do you have painful periods? Yes ◯ No ◯

Are you having urinary problems (pain, frequency, leaking, urgency) Yes ◯ No ◯