MICHIGAN
WOMEN'S HEALTH
A Division of Michigan Healthcare Professionals
WWW.MICHIGANWOMENSOBGYN.COM

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28555 Orchard Lake Road, Suite 120
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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? ___

Vaginal or C Section Birth? _____ VTP Miscarriages _____ Stillbirth _____

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? _____

Last colonoscopy _____ Where _____

Last bone density test _____ Where _____

Family history of breast or gynecological cancers? Yes ◯ No ◯

If yes, what type of cancer? Any ☐ Uterine ☐ Ovarian ☐ Cervical ☐

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: _____

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

Smoker? Yes ◯ No ◯ If no, were you a smoker in the past? ___ If so, how long? _____

Alcohol? Yes ◯ No ◯ If no, did you consume alcohol regularly in the past? _____

Drugs? Yes ◯ No ◯ If no, did you use drugs in the past? _____

Please see reverse for more questions ⟶

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OBGYN QUESTIONNAIRE CONTINUED

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 ◯

Any other past gynecological history? _____