



MICHIGAN WOMEN'S HEALTH

A Division of Michigan Healthcare Professionals
WWW.MICHIGANWOMENSOBGYN.COM

FARMINGTON HILLS OFFICE

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? _____
