

Oakdale OB/GYN

Patient Name: _____ DOB: _____ Today's Date : _____

Date of Appointment: _____ Time of Appointment: _____

Appointment with Dr. or CNP _____

Oakdale OB/GYN is in the process of converting your chart to an Electronic Medical Record. It is important that you complete this document by answering every question to the best of your knowledge.

It is critical that we receive the completed questionnaire at least **7 days prior** to your scheduled appointment. **PLEASE DO NOT wait and bring this questionnaire with you to your appointment.**

Please mail the questionnaire back to us in the provided envelope or FAX to 763-587-7015.

If you have questions or concerns regarding this questionnaire please call 763-587-7047.

Reason for your visit:
Who is your primary care provider (not OB GYN)?
List any other health care providers you see.

Screening Tests and when they were last performed				
Pap Test	Date:	Any abnormal?	No	Yes
If abnormal, how treated:				
Mammogram	Date:	Any abnormal?	No	Yes
Cholesterol	Date:	Normal	High	
Colonoscopy/ Sigmoidoscopy	Date:	Any abnormal?	No	Yes
Bone Density (DXA)	Date:	Any abnormal?	No	Yes
How much calcium (servings or milligrams) do you get in a day?				
Date of Tetanus vaccine				

Current Medications Prescription and over the counter medications including vitamins, and herbal medications. Also list prescription birth control.			
Medication	Dose	Medication	Dose

Medication	Dose	Medication	Dose
Allergies (drugs, food, medical products)		Reactions	

Medical History: Have you or any family member (parents, grandparents, aunts/uncles, siblings, children) ever been diagnosed with any of the following conditions?		
Self and age at diagnosis	Condition	Relative(s) and age at diagnosis
	Breast cancer	
	Ovarian cancer	
	Uterine/Endometrial cancer	
	Colon cancer	
	Colon polyps	
	Osteoporosis/Osteopenia	
	Heart attack/Heart disease	
	Stroke	
	Clots in legs or lungs (DVT or pulmonary embolism)	
	Diabetes	
	Thyroid disease	
	High blood pressure	
	High cholesterol	
	Depression	
	Urine leakage	

Please list all past surgeries:	
Surgery	Date

Gynecological History	
Are you in menopause? No Yes	Age of Onset
SKIP THE INFORMATION BELOW IF YOU ARE IN MENOPAUSE	
Age of first menses (period)	Cycle Regular Yes No
Menses duration (days of bleeding)	Flow(none, light, medium, heavy)
Number of pad/tampons per day	Cramps: None Mild Moderate Severe
Bleeding between periods Yes No	Do you have abnormal periods? Yes No
Last menstrual period (date):	
Method of birth control	How long have you used it?
Pain with intercourse? Yes No	

OB History						
Total number of Pregnancies				Tubal Pregnancies		
Living (birth) children				Miscarriages		
Full term babies				Abortions		
Premature babies						
SKIP THE INFORMATION BELOW IF YOU ARE IN MENOPAUSE						
Birth Date	Weeks Gestation	Baby's Weight	Baby's Sex	Type of Delivery	Physician	Complications

Social History						
Marital Status: Single Partnered Engaged Married Divorced Widowed						
Your occupation				Spouse/Partner Name		
How much alcohol do you drink in a typical week?						
Do you smoke? Never Quit Yes How many per day?						
Do you want help to quit? Yes No						
How much do you exercise? 1x week 1-3x week 4 or more x week active but no formal exercise						
Are you afraid of your spouse/partner/significant other/family member? Yes No						
Do you always wear a seat belt? Yes No						
Would you like to be tested at your visit for sexually transmitted infections? Yes No						

MD/CNP Signature _____

Date _____

Medicare Patients: Answer the following questions if you are <u>50 years or older</u> :	
Did you start having sexual intercourse before age 16?	Yes No
Have you had more than 4 sexual partners?	Yes No
Have you had a sexually transmitted disease?	Yes No
Have you had less than 3 pap tests in the past 7 years?	Yes No
Did your mother take diethylstilbestrol (DES) while pregnant with you?	Yes No

Medicare Patients: Answer the following questions if you are <u>less than 50 years</u> old		
Have you had cervical or vaginal cancer?	Yes	No
Have you had an abnormal pap test in the past 3 years?	Yes	No