

Oakdale OB/GYN

New GYN Patient Questionnaire

Date: _____

Patient name: _____

Date of birth: _____

Reason for your visit today:
Primary Care Physician:

HEALTH MAINTENANCE AND SCREENING TESTS & WHEN THEY WERE <u>LAST</u> PERFORMED				
Pap Test Date:				
Any abnormal Pap results:		Yes	No	
If abnormal Pap result please list the YEAR of abnormal result:				
If abnormal Pap how was it treated?				
Mammogram	Date:	Any abnormal:	Yes	No
Cholesterol	Date:	Normal	High	
Diabetes Screening	Date:	Normal	High	
Thyroid Screening	Date:	Low	Normal	High
Colonoscopy/ Sigmoidoscopy	Date:	Any abnormal:	Yes	No
Bone Density (DXA)	Date:	Any abnormal:	Yes	No
How much calcium (servings or milligrams) do you get in a day?				
Date of Tetanus vaccine				

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?	None	1x week	1-3x week	4 or more x week		
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				

OB HISTORY						
Total number of Pregnancies				Tubal Pregnancies		
Living (birth) children				Miscarriages		
Number of full term deliveries				Abortions		
Number of premature deliveries						
Birth Date	Weeks Gestation	Baby's Weight	Baby's Sex	Type of Delivery	Physician or Hospital	Complications

GYNECOLOGICAL HISTORY			
Are you in menopause?		Yes	No
Note: You may skip the following questions if you are in menopause.			
Last menstrual period (1 st day)			
Cycle Regular:		Yes	No
Flow:	Light	Medium	Heavy
Cramps:	None	Mild	Moderate Severe
Do you bleed between periods:		Yes	No

CURRENT MEDICATIONS - Prescription and over the counter medications including vitamins, and herbal medications. Also list prescription birth control.			
Medication	Dose	Medication	Dose

ALLERGIES (food, medication, other)			
List allergy	List reaction	List allergy	List reaction

MEDICAL HISTORY -Have you or any family member (parents, grandparents, aunts/uncles, siblings, children) ever been diagnosed with any of the following conditions?		
Condition	Please indicate if you ever had any of these diseases.	List family member that had any of these diseases.
STD (sexually transmitted diseases)		XXXXXXXXXXXXXXXXXX
Herpes		XXXXXXXXXXXXXXXXXX
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		
Asthma		

Please list all past surgeries			
Surgery	Date	Surgery	Date

Patient Signature: _____

Date: _____

MD/CNP Signature: _____

Date: _____

Medicare Patients –

Please answer the following questions if you are 50 years or older:

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

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