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University Health OB/GYN

TMC TRUMAN MEDICAL CENTERS | Better. For Everyone.

Gynecology Questionnaire

Name ________________________________ Date ____________ Date of Birth* __________ Age ______
Race* __________________ Ethnicity* ___________________ Primary Language* _____________________
*Required by Healthcare/Meaningful Use Legislation
Cell Phone_____________________ Home Phone _____________________ Work Phone ___________________
Preferred Pharmacy ________________________ Location ________________________ Phone# ________________

If English is not your primary language, do you need a translator? (please circle) YES NO

Well Woman Update (Please provide results & dates) Primary Care Doctor & location ___________________________________

Last Pap smear _________________(month/year)
Last mammogram ____________________(year)
Last colonoscopy _____________________(year)
Last bone density exam ________________(year)

Last tetanus shot _____________(year)
HPV/ Gardasil Vaccine series completed? ____ YES ___ NO
Have you had the Hepatitis B vaccine series? ___ YES ___ NO

Any abnormal Pap smears? ______YES______NO
Cervical Dysplasia (precancerous cells of the cervix)? ______YES______NO

If yes, any treatment? Dates:
LEEP ______________________________
Laser ______________________________
Cryo (freezing) ______________________________
Cone Biopsy ______________________________

Medical History: Do you now have or have you ever had:

☐ Anemia
☐ Asthma
☐ Autoimmune disorder
____
☐ Bleeding Disorder
☐ Blood transfusion
☐ Bone/Joint Disease
☐ Cancer __________
☐ Chicken pox/Shingles
☐ Chlamydia
☐ Deep Vein Thrombosis
☐ Dementia
☐ Depression/Anxiety
☐ Diabetes in Pregnancy
☐ Diabetes Type I
☐ Diabetes Type II
☐ Endometriosis
☐ Fibroids
☐ G.I. illness _____
☐ GERD/Reflux
☐ Gonorrhea
☐ Heart disease
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ High Blood Pressure
☐ High cholesterol
☐ HIV
☐ HPV/genital warts
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Infertility
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Liver Disease
☐ Migraines
☐ Osteoporosis
☐ Pelvic inflamm. disease
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Syphilis
☐ Trauma
☐ Tuberculosis

Other___________________________
____
____
____

Surgical History: List ALL surgical procedures & year
____
____
____
____
____
____
____
____

Anesthesia Complications: Check those that apply
☐ Excessive difficulty waking up
☐ Difficult intubation
☐ Malignant Hyperthermia

Medications & Allergies: (attach list &/or bring bottles)
Current names & doses ______________________________
____
Vitamins/Supplements ______________________________
Allergies/Reactions ________________________________

Family History: If mother/father are deceased, list age. Please fill out the cancer questionnaire as well.

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other relative
Diabetes (type)									
Heart Disease									
Osteoporosis									
Genetic Disease									
Other									

PLEASE COMPLETE BOTH SIDES

Reproductive History: Menstrual Cycle

Age at first period? _________ If menopausal, age at menopause: __________

How often do you get your menstrual cycle? Every __________ days, lasting ______ days.

Are your periods painful? □ Severe □ Moderate □ Mild □ No

Are your cycles? □ Regular □ Irregular

Do you have sex with anyone? □ Yes □ No □ Never

□ Men □ Women □ Both

Method of birth control:

□ None □ Vasectomy □ Rhythm Method □ Nexplanon □ Tubal Ligation

□ Diaphragm □ Condoms □ NuvaRing □ Mirena IUD □ Essure

□ Pill ___________ □ Patch □ Depo-Provera □ ParaGard IUD □ Other ________________

Obstetrical History

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birth date.

Type: vaginal, c-section, forceps, or vacuum **Anesthesia**: epidural, local, general, spinal

Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.

If preterm labor, were medications used?

	Birth date	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location
EXAMPLE:	01/15/75	40	12hrs	6 lb. 2 oz.	F	Vaginal	Epidural	HBP. Gest. Diabetes.	Truman

Social History

Occupation:____

Are you? ☐ Married ☐ Single ☐ Engaged ☐ Significant other ☐ Divorced ☐ Widowed

Emergency Contact: ____Phone#_______________________________

Tobacco Use: □Never □Current_____# of Cigarettes per day □Former, Quit at age _____ □ Other______________

Any alcohol use? ☐ Yes ☐ No *If yes, the average number of drinks per week ____________________

Do you use street drugs? ☐ Yes ☐ No *If yes, the type used and last use ______________________________

How many times and how long per week do you exercise? (circle) 1x 2x 3x 4x 5x+

Per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? ☐ Daily ☐ Some ☐ No

Any history of violence or abuse in your current household or in your past? □ Yes □ No

Do you wear your seatbelts in the car? □ Yes □ No Do you have smoke detectors at home? □ Yes □ No

Do you have any cultural or religious considerations that need special attention? □ Yes □ No

Patient Signature: ____ Date:_______________________________

PLEASE COMPLETE BOTH SIDES