Dedicated to Women | OB/GYN

Gyn Health History Questionnaire

Patient ID#: _____

Date: _____

Name: _____ Date of Birth: _____Age: _____ Last menstrual period _____

Martial Status?: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other Relationship

Do you have any of the following medical problems? If so, when did symptoms first appear?

☐ Diabetes	☐ Osteoporosis	☐ Osteopenia
☐ High Blood Pressure	☐ Glaucoma	☐ Sickle Cell Disease/Trait
☐ High Cholesterol	☐ Hypothyroidism	☐ Migraines
☐ Heart Disease	☐ Hyperthyroidism	☐ Clotting Disorder
☐ Mitral Valve Prolapse	☐ History of Blood Clot in Leg or Lung	
☐ Kidney Disease	☐ Depression	*Please check all that apply and add date of diagnosis.*
☐ Asthma	☐ Cancer – What type?_____	
☐ Arthritis	☐ Other_____	

Have you ever had?: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Herpes ☐ HPV (genital warts)

Have you ever had an abnormal Pap? ☐ YES ☐ NO If yes, in what year? _____

If yes, did you have any of the following procedures? *(Check those that apply):*

☐ Colposcopy and biopsy ☐ Cryosurgery *(freezing of the cervix)*

☐ LEEP *(minor surgery to remove part of the cervix)* ☐ Cone biopsy *(minor surgery to remove part of the cervix)*

Have you completed all or part of the HPV vaccination series? ☐ YES ☐ NO When? _____

Have you had?: ☐ Vaginal hysterectomy ☐ Abdominal hysterectomy ☐ Supracervical hysterectomy

☐ Laparoscopic assisted hysterectomy ☐ Total laparoscopic hysterectomy ☐ Both ovaries removed

Please list any other operations you have had:

_____

_____

Do you have any allergies or know reactions to: Latex? ☐ YES ☐ NO Betadine/Iodine? ☐ YES ☐ NO

Please list any Medications you are allergic to:_____

_____

Other allergies?_____

Please list prescriptions and non-prescription medicines, vitamins, herbs, etc that you take.(Dosage not necessary).

_____

_____

_____

→

Please list anyone in your family (parents, siblings, children, grandparents, aunts, uncles, and cousins) with the following diseases:

☐ Diabetes:	☐ Osteoporosis:
☐ Heart Disease *(e.g., heart attacks)*	☐ Breast Cancer (include age at diagnosis)
☐ High Blood Pressure:	☐ Ovarian Cancer (include age at diagnosis)
☐ Blood Clot in the leg:	☐ Blood Clot in the lung:

Are your periods regular (about once a month)? ☐ YES ☐ NO How many days between cycles? _____
Are they painful? ☐ YES ☐ NO Are they heavy? ☐ YES ☐ NO
Have you gone through menopause? ☐ YES ☐ NO How old were you?_____
Have you had bleeding since menopause? ☐ YES ☐ NO
Are you sexually active? ☐ YES ☐ NO What do you use for contraception? _____

How many times have you been pregnant? _____ How many abortions?_____
How many vaginal births?_____ How many miscarriages?_____
How many C-sections? _____ How many ectopics? _____

Do you smoke/vape? ☐ YES ☐ NO If Yes, how much?_____
Have you ever smoked? ☐ YES ☐ NO How long? _____ Age started _____ Age stopped _____
Do you drink alcohol? ☐ YES ☐ NO Amount and frequency: _____
Do you use recreational or illegal drugs? ☐ YES ☐ NO Which? _____ Amount _____

What is your occupation? _____

What is your Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Native American Indian ☐ Other_____ ☐ Pacific Islander

Do you exercise regularly? ☐ YES ☐ NO What activity & how many times a week? _____

Date of your last Pap smear?_____ Was it normal? ☐ YES ☐ NO
Date of your last Mammogram? _____ Was it normal? ☐ YES ☐ NO
Date of your last Colonoscopy? _____ Was it normal? ☐ YES ☐ NO
Date of your last Bone Density Test?_____ Was it normal? ☐ YES ☐ NO
Date your Cholesterol was last checked? _____ Was it normal? ☐ YES ☐ NO

Who is your primary care physician? _____

Has anyone close to you ever hurt you? ☐ YES ☐ NO Do you currently feel safe where you live? ☐ YES ☐ NO

Are you currently under care for mental health care by another provider? ☐ YES ☐ NO

Have you ever been diagnosed with a mental health condition? ☐ YES ☐ NO

If yes, please provide diagnosis: _____