OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: ____ Age: _________ Date of Birth: ____ /____ /______

Main reason for today's visit? ____

Marital Status: ☐Single ☐Married ☐Divorced ☐Long-term relationship ☐Widowed

MENSTRUAL HISTORY

(complete even if post-menopausal or no longer having periods)

- Age of first period: ______years.
- If your menstrual periods are regular; period start every: ______ days.
- If your menstrual is irregular; period starts every: ______ to ______ days. (e.g., 12 to 60)
- Duration of bleeding: ______ days. Clots? ☐Yes ☐No
- Does bleeding or spotting occur between periods? ☐Yes ☐No
- Does bleeding or spotting occur after intercourse? ☐Yes ☐No
- First day of last menstrual period: _______________
- Is pain associated with periods? ☐Yes ☐No ☐Occasionally
- If yes, is it: ☐Before menses ☐During menses ☐Both
- What birth control method(s) do you currently use? ______________________________

PREGNANCY HISTORY (ALL PREGNANCIES)

(Obstetrical history including abortions & ectopic [tubal] pregnancies)

Date of Delivery	Duration of Pregnancy Full Term 37-41wks Preterm <37wks	Type of Delivery Vaginal, C-section or Vacuum	Note Complications Mother and/or Infant • Preeclampsia • Gestational Diabetes • Premature Labor • Other/Specify	Child's Sex	Child's Birth Weight	Anesthesia Epidural Spinal General Local None?

TOTAL NUMBER OF PREGNANCIES? _________ MISCARRIAGES? _________ TERMINATIONS? _________

PAST SURGICAL HISTORY (NOT OB/GYN): List all surgeries and their years or ☐None

Surgery	Mo/Year

PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: Check any that apply or ☐None

SURGERY	YEAR	SURGERY	YEAR
☐D&C		☐Ovarian Surgery	
☐Hysteroscopy		☐L Cyst(s) removed ovarian	
☐Infertility Surgery		☐R Cyst(s) removed ovarian	
☐Tubal Ligation		☐L ovary removed	
☐Laparoscopy		☐R ovary removed	
☐Hysterectomy (Vaginal)		☐Vaginal or bladder repair for prolapse or incontinence	
☐Hysterectomy (Abdominal)		☐Cesarean section	
☐Myomectomy		☐ Other (specify)________________________________	

PAP SMEAR/MAMMOGRAM HISTORY

- Date of last pap smear: ________________: ☐Normal ☐Abnormal
- Have you had abnormal pap smears? ☐Yes ☐No
- Have you had treatment for abnormal pap smears? ☐Yes ☐No
- If yes, what type(s) of treatment have you had?
  - ☐ Colposcopy ☐ Cone Biopsy
  - ☐ Cryotherapy ☐ Loop Excision (LEEP)
- Date of last mammogram: _________________
- Have you had an abnormal mammogram? ☐Yes ☐No

OTHER PAST GYNECOLOGICAL HISTORY: Check any that apply or ☐None

☐VENEREAL WARTS ☐HERPES-GENITAL ☐PELVIC INFLAMMATORY DISEASE ☐PCOS
☐ENDOMETRIOSIS ☐CHLAMYDIA ☐POST MENOPAUSAL BLEEDING ☐POST MENOPAUSAL
☐HPV ☐SYPHILIS ☐HIV
☐FIBROIDS ☐GONORRHEA ☐OTHER (SPECIFY) ________________________________

CURRENT MEDICATIONS (include dose/amount per day)

MEDICATION	DOSE	MEDICATION	DOSE

DRUG ALLERGIES: ☐NO ☐YES, LIST NAME & REACTION

DRUG	REACTION

Women's Group of Gwinnett

PAST MEDICAL HISTORY: Check any that apply or ☐None

☐ARTHRITIS
☐HIGH BLOOD PRESSURE
☐BREAST CANCER
☐DIABETES
- ☐ DIET CONTROLLED
- ☐ PILL CONTROLLED
- ☐INSULIN CONTROLLED
- ☐GESTATIONAL

☐HEART CONDITION (SPECIFY)________
____
____
☐SKIN CONDITION (SPECIFY)__________
____
____

☐KIDNEY DISEASE
☐ASTHMA
☐ANXIETY
☐BIPOLAR
☐DEPRESSION
☐MIGRAINES
☐HEMERRHOIDS
☐HIV+
☐BLOOD TRANSFUSIONS
☐BLOOD CLOTS LEG/THIGH/PULMONARY
☐OSTEOPENIA/OSTEOPOROSIS
☐CANCER (SPECIFY)_________________
____
____

☐THYROID DISEASE
- ☐ HYPOTHYROIDISM
- ☐HYPERTHYROIDISM

☐HEPATITIS, LIVER DISEASE
☐OTHER (SPECIFY)__________________
____
____
____
____
____
____
____
____
____

DO YOU CURRENTLY?

SMOKING:	☐ Never ☐ Former	☐ Yes, Packs/Day: _____ Years Smoked? _____ Age Stopped? _____	☐ Cigarettes ☐ Vape ☐ Hookah
ALCOHOL:	☐ Never	☐ Former	☐ Yes, Drinks/Week _____
ILLICIT DRUGS:	☐ Never	☐ Former	Yes, Type: _______________
EXERCISE REGULARLY:	☐ No	☐ Yes	Days/Week ______________

FAMILY HISTORY or ☐None

	Yes	Estimate age at Diagnosis	Affected Relatives (Father, Mother, Brother, Sister, Son, Daughter, MGM, PGM, MGF, PGF)
DIABETES			
OVARIAN CANCER			
HEART DISEASE			
ENDOMETRIAL CANCER			
BREAST CANCER			
COLON CANCER			

Have you had genetic screening, such as BRCA? ☐Yes ☐No