Earle Oki, MD Professional Corporation

Maternal-Fetal Medicine, Prenatal Diagnosis and High Risk Obstetrics

NEW OBSTETRICS AND GYNECOLOGY PATIENT QUESTIONNAIRE

Name_____ DOB_____ Date_____

Age_____ WT_____ HT_____ Marital Status: Single❑ Married❑ Widowed❑ Divorced❑

Primary Doctor_____ Partner ❑ Name _____

Referred By_____ Spouse ❑ Name _____

Occupation_____

Reason for Visit_____

_____

_____

Latex Allergy? ❑Yes ❑No Other Allergies_____

Current Medication_____

Menstrual History_____ **Birth Control Method, if any**_____

Date of last period (first day)_____ Are you trying to become pregnant? ❑ Yes ❑ No

Age at Onset_____ Usual Duration_____ days If so, how long?_____

Cycle & Length _____ days (from start to start) Do you plan pregnancy in the future? ❑ Yes ❑ No

If so, when?_____

	No	Yes
Are you menopausal?	❑	❑
Do you wear tampons?	❑	❑
Have heavy flow?	❑	❑
Have pains or cramps	❑	❑
Have irregular periods?	❑	❑
Have bleeding between periods?	❑	❑
Have premenstrual difficulties?	❑	❑

Gynecologic History

Date of last pap smear _____

Obstetric History: List all pregnancies, including miscarriages and / or abortions

Year	Sex (B or G)	Birth Weight (Lbs - Ozs)	Duration Of Preg (Mos/Wks)	Duration of Labor	Type of Delivery	Complications

Have you ever had	No	Yes		No	Yes	Space Below for Doctor's Use
Yeast (Monilia)	❑	❑	Gonorrhea	❑	❑	
Trichomonas	❑	❑	Chlamydia	❑	❑	
Bacterial Vaginosis (Hemophilus or Gardnerella)	❑	❑	Syphilis	❑	❑	
			Pelvic Inflammatory Disease (PID)	❑	❑	
Genital Herpes	❑	❑	Ovarian Cancer	❑	❑	
Genital Warts (Condyloma)	❑	❑	Uterine Cancer	❑	❑	
HIV Testing	❑	❑	Fibrocystic Breasts	❑	❑	
Abnormal Pap Smear	❑	❑	Breast Biopsy or Surgery	❑	❑	
Colposcopy	❑	❑	Mammogram	❑	❑	
Laser Treatment	❑	❑	Breast Cancer	❑	❑	
Cryosurgery/Freezing	❑	❑	Uterine Fibrosis	❑	❑	
Cone Biopsy	❑	❑				
Cervical Cancer	❑	❑				
Had an IUD	❑	❑	For how long?_____			
Taken Birth Control Pills	❑	❑	For how long?_____			
Taken Estrogen	❑	❑	For how long?_____			
Tubal Ligation Date	❑	❑	Ovarian Cyst	❑	❑	
D & C Date	❑	❑	Endometriosis	❑	❑	
Laproscopy Date	❑	❑	Infertility	❑	❑	
Hysterectomy Date	❑	❑	Sexual Assault or Injury	❑	❑	
Bladder Surgery Date	❑	❑	Leakage of Urine	❑	❑	

Other Female Surgery and Date_____

Did you mother take DES when pregnant with you? ❑ Yes ❑ No ❑ Unknown _____

General Medical History

Have you ever had	No	Yes		No	Yes
High Blood Pressure	❑	❑	Anemia	❑	❑
High Cholesterol	❑	❑	Blood Transfusion	❑	❑
Heart Disease	❑	❑	Varicose Veins	❑	❑
Heart Murmur	❑	❑	Thrombophebitis	❑	❑
Rheumatic Fever	❑	❑	or blood clots	❑	❑
Pneumonia	❑	❑	Substance Abuse	❑	❑
Asthma	❑	❑	Hepatitis	❑	❑
Tuberculosis	❑	❑	Jaundice	❑	❑
Mononucleosis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Gallstones	❑	❑
Thyroid Disease	❑	❑	Colitis	❑	❑
Urinary Infection	❑	❑	Rectal Bleeding	❑	❑
Kidney Disease	❑	❑	Ulcers	❑	❑
Excessive Hair Growth	❑	❑	Frequent or Severe		
Acne	❑	❑	Headaches	❑	❑
Skin Disease	❑	❑	Migraines	❑	❑
Arthritis	❑	❑	Convulsions	❑	❑
Osteoporosis	❑	❑	Depression	❑	❑
Spine, hip, or knee problem	❑	❑	Insomnia	❑	❑
Cancer	❑	❑	Night Sweats	❑	❑

Space Below for Doctor's Use

Additional Comments_____

List any surgery (other than gynecologic) and date_____

Health Habits

Do you:	No	Yes	
Smoke	❑	❑	Packs/day_____
Drink Alcohol	❑	❑	Drinks/week_____
Use Drugs	❑	❑	_____
Eat Fatty Foods	❑	❑	
Drink Caffeine	❑	❑	Cups/day_____
Sunbathe or Tan	❑	❑	
Weight Change	❑	❑	
Exercise Regularly	❑	❑	
Wear Your Seatbelt	❑	❑	
Do Breast Self-Exam	❑	❑	
Get Enough Rest	❑	❑	
Tetanus Vaccine	❑	❑	When?_____

Family History

Has any close relative had:	No	Yes		No	Yes
Breast Cancer	❑	❑	Thyroid Disease	❑	❑
Uterine or	❑	❑	Kidney Disease	❑	❑
Ovarian Cancer	❑	❑	Epilepsy	❑	❑
Other Cancer	❑	❑	Birth Defects	❑	❑
Heart Attack or Stroke	❑	❑	Osteoporosis		
High Blood Pressure	❑	❑	(brittle bones)	❑	❑
Diabetes	❑	❑			

Any religious objections to a blood transfusion? ❑ No ❑ Yes

Have you ever had blood transfusion? ❑ No ❑ Yes When?_____

Are you sexually active?_____

Do you need to discuss birth control?_____

What types have you tried?_____

Other problems you would like to discuss?_____