Obstetrics & Gynecology Questionnaire

Tristate ObGyn PC, 2900 Kirby parkway, suite 11. Memphis TN 38119

This will become part of your medical record.

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A

Name _____Date:_____Date of Birth* _____

Age_____ Race* _____ Ethnicity* _____ Primary Language*

____

Primary Care Provider (Doctor):_____

Referring Provider (Doctor):_____

Prefered Phone number_____

*Required by Healthcare/Meaningful Use Legislation.

_____**B**

Well Woman Update: (Please provide dates where applicable)

Last bone density exam _____(year)

Last colonoscopy _____(year)

Last mammogram _____(Year)

Last pap smear _____(year)

Last tetanus shot _____(year)

HPV/Gardasil Vaccine series completed? 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 _____

_____**C**

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

□ Asthma
□ Autoimmune disorder
□ Bleeding Disorder
□ Blood transfusion
□ Bone/Joint Disease
□ Cancer (type?)
□ Chicken pox
□ Chicken pox vaccination
□ Chlamydia
□ Deep Vein Thrombosis
□ Depression
□ Diabetes Type I
□ Diabetes Type II
□ Elevated cholesterol
□ Endometriosis
□ Fibroids
□ GERD/Reflux
□ G.I. illness
□ Gestational Diabetes
□ Gonorrhea
□ Heart disease
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Herpes
□ Infertility
□ Irritable Bowel Syndrome
□ HIV
□ HPV/genital warts
□ High Blood Pressure
□ Hyperthyroidism
□ Hypothyroidism
□ Liver Disease
□ Migraines
□ Osteopenia
□ Osteoporosis
□ Pelvic inflamm. disease
□ Seizures
□ Sleep Apnea
□ Syphilis
□ Trauma
□ Tuberculosis

Other:

D

Surgical History: Please list ALL surgical procedures, including year:

_____E

Current medications (include dose(amount) per day)

Medications	Dose	Frequency

Drug allergies

No____ Yes____ List:

_____

_____

_____

F

Family History: Include the age of onset and type of cancer.

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other Relatives
Cancer(Type)									
Diabetes									
DVT									
Heart Disease									
Osteoporosis									

G

Reproductive History:

Menstrual Cycle

First day of last menstrual period_____

Age at first period? _____years If menopausal, age of menopause: _____

How often do you get your menstrual cycle? Every _____ days, lasting ____ days.

Are your cycles? □ Regular □ Irregular

Describe the amount of menstrual flow □ Light □ Normal □ Heavy □ Clots

Describe the amount of menstrual discomfort □ None □ Mild □ Moderate □ Severe
Are you sexually active? □ Never □ Not currently □ Yes

Method of contraception:
□ Not Needed □ Vasectomy □ Rhythm Method □ Nexplanon □ Tubal Ligation
□ None □ Condoms □ NuvaRing □ Mirena IUD □ Essure
□ Pills □ Patch □ Depo Provera □ ParaGuard IUD □ Other

H
Past Gynecological history
Check any that apply: □ None □ Chlamydia □ Endometriosis □ Gonorrhea □ Herpes - genital
□ Syphilis □Trichomonas □ Pelvic inflammatory disease □ Others

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I
Obstetrical History
Number of pregnancies _____ Vaginal Births ____ Ectopics _____ Abortions _____
Number of living Children_____ C-Sections ____ Miscarriages _____

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

Birth-date	Weeks	Length of labor	Baby weight	Sex F/M	Type of delivery Vaginal(V) or Cesarean(C)	Anesthesia	Complications	Location

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J.
Social History
Occupation:_____
Are you? □Married □Single □Engaged □Significant other □Divorced □Widowed □Same Sex Partner
Significant other's name: _____ Phone # _____
Other emergency contact name: _____Phone # _____

Tobacco Use: □ Never □ Current ___ # of Cigarettes per day □ Former, Quit at age

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? YES____ NO_____
*If yes, 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? NO____ YES____

Current Medical Concerns:

Please circle if you have had any of the following

Weight change Yes No

Abnormal bleeding Yes No

Abnormal hair growth Yes No

Problems with urination Yes No

Nausea / Vomiting Yes No

Bowel changes Yes No

Anxiety / Panic Yes No

Depression Yes No

Trouble sleeping Yes No

Night sweats / Hot flashes Yes No Breast problems Yes No

How did you hear about us?

_____

Is there any other information you feel we should have?

Patient Signature Date Provider Signature Date