MODERN
GYNECOLOGY

PATIENT HISTORY QUESTIONNAIRE FOLLOW UP

Patient Name: _____ Age:_____ Today's Date: _____
Reason for this visit: _____

DRUG ALLERGIES: NO YES, List Name and Type of Reaction:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS/SUPPLEMENTS:

Name of Medication/Supplement	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: (Please put what family member and what side of family) **NONE**

Diabetes: _____ Breast Cancer: _____
High Blood Pressure:_____ Ovarian Cancer: _____
Heart Disease: _____ Cervical Cancer: _____
Stroke: _____ Colon Cancer: _____
Other: _____ Other Cancer: _____

SOCIAL HISTORY- DO YOU CURRENTLY?

Smoke Never Yes, _____ packs/day Former, Years smoked _____
Use alcohol No Yes How often: _____
Use illicit drugs and/or Marijuana No Yes Type/frequency: _____
Exercise: Type: _____ How often _____
Employed: No Yes Occupation: _____

PAST SURGICAL HISTORY (List all surgeries and month/year performed) **NONE**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ Please initial here if you would like a chaperone present during your exam.

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Review of Systems: Have you experienced any of the following in the **past 6 months?**

___Depression/Anxiety ___Problems with sleep ___Vomiting ___Nausea
___Diarrhea ___Constipation ___Rectal bleeding ___Hemorrhoids
___Vaginal discharge ___Vaginal odor ___Vaginal itching ___Appetite changes
___Changes in hair/nails ___Weight change ___Excessive thirst ___Abdominal pain
___Heart palpitations ___Tremors ___Hot flashes ___Fatigue
___Stiffness/joint pain ___Dizziness ___Urinary frequency ___Cough
___Difficulty swallowing ___Shortness of breath ___Chest pain ___Cold intolerance
___Bleeding w/ intercourse ___Painful intercourse ___Insomnia ___Skin changes (moles, sores) ___Breast tenderness ___Breast lump
___Nipple discharge ___Painful urination ___ Blood in urine
___Urinate during the night, how often _____

GYN HISTORY:

Are you sexually active? No Yes
What birth control method(s) do you currently use? _____
History of Sexually Transmitted Infections- Circle any that apply:
None Genital Warts/ HPV Herpes– genital or oral Syphilis Chlamydia Gonorrhea
Pelvic Inflammatory Disease (PID) Other: _____
Have you been immunized for Human Papillomavirus (HPV)? No Yes

SCREENING HISTORY

Date of last pap smear: _____
Have you had abnormal pap smears? No Yes
Have you had treatment for abnormal smears? No Yes If yes, what type(s) of treatment have you had?
Monitoring w/ Paps Laser Cone biopsy Colposcopy Loop Excision (LEEP)
Date of last mammogram: _____
Have you had an abnormal mammogram? No Yes, when_____
Do you perform monthly self breast exams? No Yes
Date of last bone density scan (DEXA): _____
Date of last colonoscopy: _____

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

Age at first period: _____
First day of last menstrual period: _____/_____/_____
Do you have monthly periods? No Yes
Duration of bleeding: _____ days
Flow: Spotting Light Moderate Heavy Clots
If your menstrual periods are regular; periods start every: _____ days
If your menstrual periods are irregular; periods start every:____ to ____ days (e.g. 12 to 60)
Does bleeding or spotting occur between periods? No Yes
Does bleeding or spotting occur after intercourse? No Yes
Is pain associated with periods? No Yes Occasionally
Age of menopause: _____ Have you had postmenopausal bleeding? No Yes

PREGNANCY HISTORY:
Total # of pregnancies: _____ # of Living Children: _____ # of Abortions: _____
# of Miscarriages _____ # of Ectopic _____ # of Premature Births (37 weeks or less): _____
# of Full Term Births: _____ # of Multiple Births: _____
# of Vaginal Deliveries: _____ # of C/S: _____
Birth weights: _____

PAST MEDICAL HISTORY (Check any that apply): **None**

	AIDS/HIV		Cancer Type:_____		Kidney Disease
	Abuse/Domestic violence		Depression		Kidney or Bladder Problems
	Acid Reflux/GERD		Dermatologic Disorders		Liver Disease
	Acne		Diabetes		Neurologic/ Epilepsy
	Anesthesia Complications		Endometriosis		Osteoporosis
	Anxiety		GI Problems		Other
	Arthritis		Headaches		Ovarian Cancer
	Asthma		Heart Attack		Polycystic Ovaries
	Autoimmune disease Type: _____		Heart Disease		Polyps
	Bleeding disorder		Hepatitis/Liver Disease		Stroke
	Hx of blood transfusion		High Cholesterol		Thyroid Problems Type:_____
	Breast cancer		Hypertension		Uterine Fibroids
	Breast Problem		Hx of Infertility		Varicosities