UPDATED **PATIENT HISTORY QUESTIONNAIRE (EVERY 6 MONTHS)**

Patient Name:___________________________________DOB:_____________ Today's Date: _______________

Reason for this visit: ____

Any changes to your:

- ☐ Address_______________________________
- ☐ Email________________________________
- ☐ Phone #_______________________________
- ☐ Insurance____________________________
- ☐ N/A

NEW GYN HISTORY: Have you been seen elsewhere for gyn care/ had any new concerns in the last 6 months?
☐ No ☐ Yes ____

What birth control method(s) do you currently use? ____

Any new Sexually Transmitted Infections? ☐ No ☐ Yes ____

Date of last pap smear:______/_____/______

Have you had abnormal pap smears? ☐ No ☐ Yes

*If yes, what type(s) of treatment have you had? ____

Date of last mammogram:______/_____/______ Facility:_______________________ Normal: ☐ No ☐ Yes

Date of last bone density scan (DEXA):______/_____/______ Date of last colonoscopy: ______/_____/______

MENSTRUAL HISTORY: Any changes to your menstrual cycle, bleeding, or pelvic pain?
☐ No ☐ Yes → explain: ____

First day of last menstrual period:______/_____/______ Are cycles occurring regularly? ☐ No ☐ Yes

Bleeding/ spotting between periods? ☐ No ☐ Yes Bleeding/ spotting after intercourse? ☐ No ☐ Yes

Age of menopause: _________ Have you had postmenopausal bleeding? ☐ No ☐ Yes

PREGNANCY HISTORY:

Any pregnancies since last visit? ☐ No ☐ Yes ____

SOCIAL HISTORY: Any changes to the following?

Tobacco/nicotine use: ☐ No ☐ Yes Alcohol use: ☐ No ☐ Yes Drug use: ☐ No ☐ Yes

Caffeine: ☐ No ☐ Yes Exercise: ☐ No ☐ Yes Employment: ☐ No ☐ Yes

If yes: ____

SURGICAL HISTORY:

Any new surgeries/ procedures since last visit? ☐ No ☐ Yes____

NEW DRUG ALLERGIES: ☐ No ☐ Yes ____

PERSONAL MEDICAL HISTORY:

Any new diagnosis, conditions, problems since last visit? ☐ No ☐ Yes_______________________________

FAMILY HISTORY:

Any new medical family history? ☐ No ☐ Yes ____

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