PeaceHealth Medical Group

OB/GYN Patient Questionnaire

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____

Name of your current Primary Care Physician (PCP)? _____

Pharmacy of choice (including location): _____

The following comprehensive questions regarding your home environment, work environment and personal history are asked in compliance with national guidelines for wellness exams.

Have you been seen at PeaceHealth Medical Group OB/GYN in the past? Yes No
What is the reason for your visit today? _____

GYNECOLOGIC HISTORY:

First day of last menstrual period: _____If menopause, what age did you have last period?_____
How often do you get your periods?_____Age periods began: _____
Do you have regular menstrual cycles? ☐Yes ☐No If no, what is the reason? _____
Age of first intercourse: _____

Sexually Active: ☐ Yes ☐ No ☐Not Currently
Partners: ☐ Male ☐ Female ☐ Both Concerns: _____
Any new partners in the past year? ☐ Yes ☐ No
Present method of birth control (including sterilization): _____

Date of last PAP: _____ Date of last Mammogram (over 40):_____

PREGNANCY/BIRTH HISTORY:

Pregnancies: _____ Full Term Deliveries: _____ Ectopic: _____
Living Children: _____ Pre Term Deliveries: _____ Abortions: _____
Deliveries: _____ Miscarriages: _____ Twins: _____

Have you ever had the following with pregnancy? (select all that apply)

☐ Hemorrhage
☐ High Blood Pressure
☐ Pre-eclampsia
☐ 3rd or 4th degree laceration
☐ Forceps
☐ Shoulder Dystocia
☐ Fetal Injury
☐ Still Birth
☐ Infant Death
☐ Vacuum
☐ Diabetes
☐ C-Section
☐ Special Needs Child
☐ Other: _____

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ALLERGIES: (list *current* allergies)

Current Allergies:	Reaction to Allergy:
_____	_____
_____	_____
_____	_____

MEDICATION: (list all *prescription* and *over-the-counter* medications that you are currently taking, *including supplements*)

Medications/Supplements:	Dosage:	Medications/Supplements:	Dosage:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY: (select all that apply)

- ☐ Abnormal PAP Smear
- ☐ Anemia
- ☐ Anesthetic Complications
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disorder/Blood Clot Issues
- ☐ Blood Transfusion
- ☐ Breast Problems
- ☐ Coronary Artery Disease (Heart Disease)
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Gestational Diabetes
- ☐ HIV/AIDS
- ☐ History of Chicken Pox
- ☐ Hypertension (High Blood Pressure)
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Mental Disorder
- ☐ Postpartum Depression
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ STD
- ☐ Uterine Problems
- ☐ MRSA

ADDITIONAL HISTORY: _____

PROCEDURE / SURGICAL HISTORY: (select all that apply)

- ☐ Appendectomy
- ☐ Bariatric Surgery (Weight Loss Surgery)
- ☐ Breast Biopsy
- ☐ Breast Lumpectomy
- ☐ Cholecystectomy (Gall Bladder Surgery)
- ☐ Colposcopy
- ☐ C-Section
- ☐ Endometrial Ablation
- ☐ Exploratory Laparotomy
- ☐ Myomectomy (Fibroid Removal)
- ☐ Genital Wart Removal
- ☐ Gynecologic Cryosurgery
- ☐ LEEP
- ☐ Mastectomy
- ☐ D & C/Hysteroscopy
- ☐ Colonoscopy
- ☐ Laparoscopy
- ☐ Cosmetic Surgery

ADDITIONAL SURGERIES: _____

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FAMILY MEDICAL HISTORY: (list all that apply)

Illness	Relative	Illness	Relative
Breast Cancer:		Miscarriages:	
Cancer:		Ovarian Cancer:	
Colon Cancer:		Preterm Labor:	
Diabetes:		Stroke/Blood Clots:	
High Blood Pressure:		Heart Attack:	
Blood Clots/Clotting Disorder:		Endometriosis:	
Menstrual Problems:		Hysterectomy:Other:	

SOCIAL HISTORY: (please select all that apply)

Current Occupation: _____

☐ Relationship Status: ☐ Single ☐ Married ☐ Living with Partner ☐ Divorced ☐ Widowed

☐ Have you ever been sexually, verbally or physically abused? Are you currently safe? (circle one) YES / NO

Alcohol Use: ☐ Never ☐ Previous ☐ Current Drinks per day: _____ # of years: _____

Drug Use: ☐ Never ☐ Previous ☐ Current: _____

Tobacco Use: ☐ Never ☐ Previous ☐ Current Packs per Day: _____ # of years: _____

Exercise: _____ times per week Type of exercise: _____

REVIEW OF SYSTEMS: Have you had any of the following symptoms in the past **30 days**?

☐ Abdominal Bloating
☐ Blood in Stool
☐ Blood in Urine
☐ Breast Problems
☐ Changes in Bowel Habits
☐ Changes in Mood
☐ Change in Vision
☐ Chest Pain
☐ Fecal Incontinence (bowel leakage)
☐ Fever/Chills
☐ Hair or Skin Changes
☐ Heat or Cold Intolerance
☐ Headaches
☐ Hearing Loss
☐ Hot Flashes
☐ Night Sweats
☐ Pain with Intercourse
☐ Painful Urination
☐ Shortness of Breath
☐ Significant Weight Change
☐ Urinary Frequency
☐ Urinary Incontinence (urine leakage)
☐ Vaginal Discharge
☐ Vaginal Dryness

_____ _____

Signature of Patient / Person Authorized to Sign for Patient – Relationship *Date* *Time*