**Return GYN Questionnaire**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age**: \_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Marital Status**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies (*reaction*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit**: *Annual Problem*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st day of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_ # of days bleeding: \_\_\_\_\_days How many days between: \_\_\_\_days

Is your flow: *heavy medium light* Do you have pain with your period? *Yes No*

**Are you menopausal**? *Yes No* **Have you had a Hysterectomy**? *Yes No* **Do you have your ovaries**? *Yes No*

**Do you take hormones**? *Present Past No*

Type of Birth Control: *pill Vasectomy Tubes tied Essure IUD* **other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you sexually active**? *Yes No* **Would you like to be checked for***: STD’s HPV Neither*

Have you had the HPV vaccine? *Yes No* Flu vaccine? *Yes No Pneumonia vaccine? Yes No*

**Social History**: Do you Smoke? *Never Former Yes* Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you drink Alcohol? *Never Former Yes* Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you drink Caffeine? *Yes No* Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you Exercise? *Yes No Active* Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Illegal Drug Use*? Never Former Yes* What and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bone Health**: Have you had a Bone Density Scan*? Yes No* When? \_\_\_\_\_\_\_\_\_\_\_\_ Was it normal? *Yes No*

Do you take Calcium supplements? *Yes No* Do you take a multivitamin? *Yes No*

**Digestive History**: Have you had a Colonoscopy? *Yes No* When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Breast Health**: Do you do self breast exam? *Yes No* When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any new medical problems, family history, tests or surgical procedures you may have had since your last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy** (Please include location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE INCLUDE A COPY OF VITAMINS, PRESCRIPTION AND OVER THE COUNTER MEDICATIONS THAT YOU TAKE. *YOU MAY WRITE THEM ON THE BACK****.*