# W Gynecology Questionnaire

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

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

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

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

Date of last Pap Smear: \_\_\_\_\_\_\_\_ Was it normal? *Yes No*

**Gynecological History**: 1st day of last period: \_\_\_\_\_\_\_\_\_ # of days bleeding: \_\_\_\_\_\_days

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

 Type of Birth Control: *pill Vasectomy Tubes tied Essure IUD Condoms Natural Family planning*

Have you had the HPV vaccine? *Yes No* Would you like it today? *Yes No*

Are you sexually active? *Yes No* Would you like to be checked for *STD’s*? *Yes No*

Are you menopausal? *Yes No* If yes, what age? \_\_\_\_\_

Have you had a Hysterectomy? *Yes No* If yes? *Abdominal Vaginal Laparoscopic*

Do you have your ovaries? *Yes No* Reason for Hysterectomy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Reproductive History**: # of pregnancies: \_\_\_\_\_ # of Children: \_\_\_\_\_ # of miscarriages: \_\_\_\_\_

*Date of delivery* *Weight*  *Sex* *Type of delivery Complications*

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_ *c-section vaginal* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_ *c-section vaginal* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_ *c-section vaginal* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Breast History**: Have you had a Mammogram? *Yes No* If yes: *Normal Abnormal*

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? ACC STRIC MAP HCMH (Fredericksburg)

Do you do a self breast exam? *Yes No* Do you or your family have a history of Breast Cancer? *Yes No* If yes, Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**: ( include type of procedure, and date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**: Illegal Drug use? *Never Former Yes* What and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 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: \_\_\_\_\_\_\_\_\_\_\_\_

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

Any *self* or family history of Osteoporosis? *Yes No* Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Digestive History**: Have you had a colonoscopy? *Yes No* If yes When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was it normal? *YES NO* Do you have history of: *hemorrhoids rectal bleeding*

Any self or family history of Colon Cancer? *Yes No* If yes Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal or Family History**: *Self*, Mother, Father, Sister, Brother, Aunt, Uncle, Maternal (grandmother, grandfather), Paternal (grandmother, grandfather)

High Blood pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke/DVT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

List any recent labs done (Which lab do you use CPL or Hospital):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy (local):** HEB #1 HEB #2 CVS WalMart Walgreens Kerr Drug Med Stop MAP Pharmacy Annie’s Frontier Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take a Multivitamin? *Yes No* Calcium Supplement? *Yes No*

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

Have you had a flu shot? Y/N When?\_\_\_\_\_\_\_\_\_ Have you had pneumonia shot? Y/N When? \_\_\_\_\_\_\_\_