**Return GYN Questionnaire**

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

**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* Condoms Natural Family planning

**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* Would you like it today? *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*

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

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

Where? ACC MAP HCMH (Fredericksburg) STRIC Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List new diagnoses or surgeries since last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Pharmacy**: HEB #1 HEB #2 CVS WalMart Walgreens Med Stop MAPpharmacy Frontier Anne’s

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE INCLUDE A COPY OF VITAMINS, PRESCRIPTION AND OVER THE COUNTER MEDICATIONS THAT YOU TAKE. *YOU MAY WRITE THEM ON THE BACK****. Do you take a Multivitamin? Y/N Do you take a Calcium Supplement? Y/N*

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