

FEMALES- 40yrs.+ GYN QUESTIONNAIRE

DATE
D.O.B.

NAME

OCCUPATION/ EMPLOYER

REASON FOR VISIT TODAY

PAST MEDICAL & FAMILY HISTORY (please check if you or any blood relative have had)

	SELF	FAMILY		SELF	FAMILY
Weight gain/ loss			Blood transfusions		
Headaches/ migraines			Anemia/ blood disorders		
Heart disease			Vericose veins		
Vascular disease			Phlebitis		
Rheumatic disease			Skin disease		
High blood pressure			Diabetes		
High cholesterol			Thyroid disease		
Respiratory disease			Cancer type		
Breast disease			Pulmonary disease		
Jaundice/hepatitis			Epilepsy		
Hiatal hernia/ reflux			Neurological disease		
Peptic ulcer			Arthritis		
Bowel disease			Joint pain		
Kidney disease			Osteoarthritis/ fragile bones		
Urinary disease			Anxiety		
Urinary infections			Depression		
Sleep problems					

HOSPITAL ADMISSIONS (list operations/illnesses which required hospitalizations) excluding pregnancy

YEAR REASON

MEDICATIONS:

MENSTRUAL HISTORY: Age at first period? Date of last period? Period intervals (# of days)

Cramps y n mild moderate severe always present do you use meds for cramps?

How many periods in the last year Bleeding/ spotting between periods y n

VAGINAL INFECTION: History of yeast trichomonas Chlamydia herpes gonorrhea

PAP TEST: date of last test normal/ abnormal **MAMMOGRAM:** date of last test normal/ abnormal

CONTRACEPTIVE : current method if pill; brand past methods

OBSTETRICAL: # of pregnancies premature babies miscarriages abortions living children

MENOPAUSAL: hot flashes y n vaginal dryness y n palpitations y n disrupted home/work y n

Excessive fatigue y n memory loss y n recent bone fractures y n treatment

SEXUAL HISTORY: satisfactory uncomfortable wish to discuss

SOCIAL HISTORY: smoking cig/day #yrs. Alcohol ozs./wk coffee cups/ day street drugs