



Overlake Reproductive Health

NEW GYNECOLOGICAL PATIENT QUESTIONNAIRE

IDENTIFYING INFORMATION:

Date: ____/____/____ (of first visit)

Name: _____

Age: _____ yrs Birth date: ____/____/____

Address: _____

City/State/Zip: _____

Telephone (day): (____) _____ (evening): (____) _____

Occupation: _____ Company: _____

Reason for visit: _____

What are your expectations for this visit? _____

What questions do you want answered at this visit? _____

How did you hear about us? (Please be as specific as possible)

Physician

Name _____ Phone (____) _____

Address _____

Former Patient/Friend _____

Web Site _____ Advertisement _____

Insurance (Name of Insurance) _____

Who is your OB/GYN?

Name _____ Phone (____) _____

Address _____

Who is your Primary Care Physician?

Name _____ Phone (____) _____

Address _____

**I. GYNECOLOGICAL HISTORY:
FEMALE: (Menstrual and Pregnancy History)**

Total # of all pregnancies: _____

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

Date Pregnancy ended or delivered	Length of Pregnancy	How long to conceive	Result	Infertility Therapy?
1.	wks			
2.	wks			
3.	wks			
4.	wks			
5.	wks			

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

- Explain:
1. _____
 2. _____
 3. _____
 4. _____

Did you require? (circle pregnancies that apply):

- | | | | | | |
|-------------------|---|---|---|---|---|
| C-section | 1 | 2 | 3 | 4 | 5 |
| Surgery | 1 | 2 | 3 | 4 | 5 |
| Blood transfusion | 1 | 2 | 3 | 4 | 5 |
| Antibiotics | 1 | 2 | 3 | 4 | 5 |
| D & C | 1 | 2 | 3 | 4 | 5 |
| Other | 1 | 2 | 3 | 4 | 5 |

- Explain:
1. _____
 2. _____
 3. _____
 4. _____

Patient Name _____

Age at first period _____yrs.

Age when you first noticed: Breast development ___yrs Pubic hair ___yrs Underarm hair ___yrs

Date of the first day of your last period ____/____/____

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next? _____

How many days does your menstrual flow last? _____

Do you consider your menstrual flow abnormal? Yes No
(circle): light heavy short long painful other _____

Do you have severe cramping or pelvic pain with your periods?
Yes: ___ Always ___ Sometimes ___ Recently ___ In the past No

Do you have pain with intercourse? Yes No

Do you spot or bleed between periods? Yes No

Do you have pelvic pain between periods? (If it is a significant problem, please complete pelvic pain questionnaire)
Yes No

Do you have premenstrual symptoms other than cramps? Yes No

Do you need medication to bring on a period? Yes No

Are your periods now, or have they ever been irregular or unpredictable? Yes No

If yes:

1. When _____
2. Average # of periods in a year _____
3. Shortest time in between periods _____
4. Longest time spent without menstruating _____

(M.D. use only) _____

Do you have acne or oily skin? Yes No

Do you have a breast discharge? Yes No

Are you currently breast feeding? Yes No

Do you have extra body hair? Yes: Where? _____ No

What has been your maximum weight? _____ When? _____

What has been your minimum adult weight? _____ When? _____

Have you ever had a sudden weight change? Yes: When? _____ No

Do you feel that you are underweight? Yes No

Do you feel that you are overweight? Yes No

Patient Name _____

How many meals do you usually eat per day? _____

Do you follow a particular food diet or have any special dietary habits? Yes No

Have you ever been diagnosed with an eating disorder, such as anorexia or bulimia? Yes No

Have you ever used self-induced vomiting to control overeating? Yes No

Do you regularly participate in any vigorous exercise? Yes No

What: _____

Number of hours _____/week Number of miles _____/week

FEMALE: (Contraceptive History)

Have you ever taken oral contraceptives ("Pill")?

Name _____ From _____ To _____

Name _____ From _____ To _____

Name _____ From _____ To _____

Did you or your doctor note any problems? Yes No

Explain _____

Was it stopped because of a problem? Yes No

Explain _____

Were there any problems with your cycles after stopping the "pills"? Yes No

Explain _____

Have you ever used injectable contraception (Depo-Provera®, Lunelle™, etc.)?

Yes: Dates of use _____ Complications? _____ No

Have you ever used an IUD? Yes No

Name _____; From _____ To _____

Name _____; From _____ To _____

Did you note any problems? Yes No

(Circle) Pain Bleeding Fever Infection

Was it removed because of a problem? Yes No

Explain _____

Have you had tubal sterilization procedure (tubes tied)? Yes: _____ Date (mnth/yr) No

If yes, have you had a tubal reversal (tubes untied)? Yes: _____ Date (mnth/yr) No

FEMALE: (Uterine, Tubal, Pelvic)

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

Yes (check all that apply) No

Chlamydia: date _____
 Gonorrhea: date _____
 Herpes: date _____
 Genital warts/HPV: date _____
 Syphilis: date _____
 HIV/AIDS: date _____
 Hepatitis: date _____
 Other _____: date _____

Have you had your appendix removed? Yes No
 (Circle one): Uncomplicated Ruptured Complicated Infection

Did your mother take any hormones when she was pregnant with you? Yes No

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? Yes No

Explain: _____

Have you ever had any of the following?

Procedure	Dates	Results
-----------	-------	---------

Endometrial Biopsy:

Hysteroscopy:

Laparoscopy:

Tubal Surgery:

Abdominal Surgery:

Other Pelvic Surgery:

Have you ever been noted to have or been treated for endometriosis? Yes No

Treatment: _____

II. FEMALE FAMILY HISTORY

Relative	Alive/Dead	Age
Mother _____	A/D _____	_____
Father _____	A/D _____	_____
Sisters/Brothers:		
1. S / B _____	A/D _____	_____
2. S / B _____	A/D _____	_____
3. S / B _____	A/D _____	_____
4. S / B _____	A/D _____	_____

Have any of your blood relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Birth defects	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Other chromosome defects	M	F	S	O
Frequent miscarriages	M	F	S	O
Stillbirths	M	F	S	O
Twins	M	F	S	O
Early menopause (before age 40)	M	F	S	O
Endometriosis	M	F	S	O
Infertility	M	F	S	O
Irregular periods	M	F	S	O
Obesity	M	F	S	O
Psychiatric problems	M	F	S	O

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel or ovarian cancer)? Yes No

III. FEMALE MEDICAL HISTORY:

Do you have or have you ever had (circle all that apply):

- | | | |
|------------------|----------------------|-----------------------|
| Scarlet fever | High blood pressure | Neurological problems |
| Rheumatic fever | Gallbladder problems | Seizures |
| Tuberculosis | Liver problems | Epilepsy |
| Hepatitis | Ulcers | Dizziness |
| Heart murmur | Appendicitis | Loss of balance |
| Pelvic infection | Colitis | Chronic headaches |
| Chicken pox | Anemia | Vaginitis |
| Thyroid problems | Arthritis | Pneumonia |
| Cancer | Breast lump | Parasites |
| Kidney infection | Breast problems | Ovarian cysts |
| Heart disease | Breast discharge | Other _____ |

Comments _____

Patient Name _____

PAP SMEAR HISTORY

When was your last pap smear? (month/year) ____/____ Normal Abnormal

When was your last abnormal pap smear? ____/____ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

Yes (check all that apply) No

Colposcopy Cryosurgery (freezing) Laser treatment Conization LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram?

Yes - date _____ Result: normal abnormal - explain _____ No

Do you perform breast self exams? Yes No

Have you ever had Rubella (German measles)? Yes No

Have you received Rubella immunization? Yes No

Have you ever undergone surgery? Yes No

Date	Type	Hospital

Were there:

Complications? Yes No

Anesthesia problems? Yes No

Bleeding problems? Yes No

Comments _____

Are you allergic to any medication, drugs, foods, metals, other? Yes (list and describe reactions) No

Do you regularly take medications? Yes No

1. Over the counter (list) Yes No

2. Prescriptions (list) Yes No

3. Are you taking any now (list) Yes No

Do you use or have you ever used:

1. Alcohol, (# of glasses per week) Wine ____ Beer ____ Cocktails ____ Yes No

2. Cigarettes, (present _____ prior _____)
packs per day _____ # of years _____ Yes No

3. Illicit or recreational drugs (specify) Yes No

_____ **Past / Present (circle)**

COUPLE FACTORS (OPTIONAL)

How frequently do you have sexual intercourse?

- More than once a day _____
- Daily or almost daily _____
- 3-5 times a week _____
- 1-2 time a week _____
- Less than once a week _____
- Irregularly _____

Which of the following best describes how you feel about your sex life?

- Very satisfied _____
- Fairly satisfied _____
- Fairly unsatisfied _____
- Very unsatisfied _____

Which of the following best describes how you think your partner feels about your mutual sex life?

- Very satisfied _____
- Fairly satisfied _____
- Fairly unsatisfied _____
- Very unsatisfied _____

Do any of these statements describe sex with your partner?

- It is sometimes difficult _____
- It is almost always difficult _____
- It is sometimes painful _____
- It is almost always painful _____
- It is sometimes unpleasant _____
- It is almost always unpleasant _____
- It is sometimes enjoyable _____
- It is almost always enjoyable _____

Do you or your partner have problems with initiating or completing sexual intercourse?

Yes No

Do you plan intercourse for a specific time of your cycle?

Yes No

When: _____

Do you use lubricant for intercourse?

Yes No

Do you douche before or after intercourse?

Yes No

Do you feel that your fertility problem is:

- 1. Causing personal stress Yes No
- 2. Causing stress between you and your husband Yes No
- 3. Interfering with a satisfactory sex life Yes No

IV. REVIEW OF SYSTEMS

General:

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other _____
- none

Endocrine/Hormonal:

- Diabetes Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance - hot flashes or feeling cold
- Other _____
- none

Gastrointestinal:

- Nausea/Vomiting Ulcers
- Hepatitis Diarrhea
- Blood in your stools Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (Ulcerative or Crohn's)
- Other _____
- none

Musculoskeletal:

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other _____
- none

Mental Health Problems:

- Depression Anxiety disorder
- Schizophrenia
- Other _____
- none

Head, Eyes, Ears, Nose and Throat:

- Dizziness Loss of sense of smell
- Headaches Chronic nasal congestion
- Blurred vision Ringing ears
- Hearing loss/deafness
- Other _____
- none

Breasts:

- Discharge: clear ___ bloody ___ milky ___
- Lumps Pain Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants
Saline ___ Silicone ___
- Other _____
- none

Genito-Urinary:

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination Leaking urine
- Blood in the urine
- Herpes
- Other _____
- none

Hematologic:

- Blood clotting disorder/Blood clot
- Sickle Cell Anemia Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons _____)
- Other _____
- none

Respiratory:

- Shortness of breath
- Asthma Bronchitis
- Pneumonia Tuberculosis
- Bloody cough
- Other _____
- none

Neurological Problems:

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other _____
- none

Skin/Extremities:

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other _____
- none

Cardiovascular:

- Palpitations/Skipped beats
- Chest pain Heart attack
- Stroke Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (need antibiotics before dental procedures? Yes ___ No ___)
- Other _____
- none

Physician Notes (for office use only) _____

V. PHYSICAL EXAM:**Office Use Only**

Height _____ Weight _____ Pulse _____ B.P. _____

Stature _____ Race _____

General Appearance: Well developed Well nourished Normal mood/affect Oriented x3
 No acute distressSkin: Acne XS Sebum Hirsutism (facial, chest, back, areolar, abd., thigh)
 No lesions No abnormal molesNeck: Supple Without massesThyroid: WNL No masses Without thyromegalyBreast: No dominant masses No skin changes No nipple dischargeLungs: Clear to auscultation bilaterally Normal respiratory effortHeart: Regular rhythm and rate No murmurs/gallopsAbdomen: Soft, non-distended No masses/HSM No herniasBack: No CVA tendernessLymphatic: No neck No axillary No groin lymphadenopathyExtremities: Without varicosities Without edema Nontender calvesPelvic Exam: Normal external genitalia Adnexa NTUrethral meatus/urethra: Without lesions, tenderness or prolapseBladder: Without masses, tenderness Well supportedVagina: Well supported No lesions No abnormal dischargeCervix: Without lesions No CMTUterus Position: Normal size & shape Nontender Without descentAdnexa: Normal size No adnexal masses No tendernessAnus/Perineum: No lesionsRectal: Normal sphincter tone No hemorrhoids No tenderness

Other Findings:

The above was discussed with the patient at the New Patient Consultation.

Signed: _____ Date: _____

