RIVERVIEW HEALTH

GYNECOLOGICAL QUESTIONNAIRE

NAME:_____ DATE: _____

Primary Care Provider: _____

Reason for visit: _____

How long have you been having problems? _____

If you have pain, how would you rate the pain on a scale from 0 to 10, where 0 is no pain and 10 is the worst possible pain: _____

Does anything make your symptoms better? _____

_____

Does anything make your symptoms worse? _____

_____

What treatment (if any) have you received for your symptoms so far? _____

_____

SOCIAL HISTORY:

Health Habits

Do you….?	Yes	No	No, but did in the past	Quit Date	If Yes:
Smoke cigarettes					Packs per day: ____ Years ____
Drink Alcohol					Drinks per week: ____ Years ____
Exercise					Hours per week: _____

PAST GYNECOLOGICAL/OBSTETRICAL SURGERIES:

SURGERY	Yes	Year	No	**SURGERY**	Yes	Year	No
D&C				Ovarian Surgery			
Hysteroscopy				Left Ovarian Cyst(s) Removed			
Infertility Surgery				Right Ovarian Cyst(s) Removed			
Tuboplasty				Left Ovary Removed			
Tubal Ligation				Right Ovary Removed			
Laparoscopy				Vaginal/Bladder Repair for Prolapse or Incontinence			
Hysterectomy (Vaginal)				Cesarean Section			
Hysterectomy (Abdominal)				Other:			
Myomectomy				Other:			

LIST PAST SURGICAL HISTORY (NOT GYN/OB):

SURGERIES	**YEAR**

FAMILY HISTORY OF GYNECOLOGICAL DISEASES:

No _____ If yes, please list:

PAST AND CURRENT MEDICAL HISTORY: Please indicate if you have had or have any of these medical problems:

MEDICAL PROBLEM	√=Yes	√=No	MEDICAL PROBLEM	√=Yes	√=No
High blood pressure			Ulcerative colitis		
Angina or chest pain			Crohn's disease		
Irregular heartbeat or palpitations			Irritable bowel syndrome		
Heart attack or coronary artery disease			Chronic constipation		
Asthma			Chronic diarrhea		
Pulmonary embolus (blood clot in lungs)			Stomach ulcer		
Chronic headaches/migraine			Reflux (heartburn)		
Thyroid disease, specify:			Interstitial cystitis		
Kidney disease, specify:			Fibromyalgia		
Liver disease, specify:			Chronic low back pain		
Cancer, specify:			Diabetes		
Blood clot in legs or arms (DVT)			Breast disease, specify:		
Urinary tract infection			Arthritis		
Other:			Other:		

Have you ever been diagnosed or treated for any of these mental health conditions?

CONDITION	**Yes**	**No**	**Month / Year Of Diagnosis**	**TREATMENT**			**Duration of Treatment**
				Medication	**Counseling**	**Hospitalization**	
Depression							
Anxiety							
Bipolar disorder							
Schizophrenia							

Allergies to medications, if so, list: _____

Current medications, please list: _____

REVIEW OF SYMPTOMS:
Please mark any symptoms that you have experienced in the last 3 months:

General	√=Yes	√=No	**Gastrointestinal**	√=Yes	√=No
Chronic fatigue			Nausea or vomiting		
Fevers			Poor appetite		
Difficulty falling or staying asleep			Abdominal bloating/fullness		
Unintentional weight loss			Heartburn		
Unintentional weight gain			Constipation		
Skin	√=Yes	√=No	Diarrhea		
Rash			Blood in stools		
Itching			Pain with bowel movements		
Vaginal or vulvar ulcers or fissures			**Urinary**	√=Yes	√=No
Head and Neck	√=Yes	√=No	Urinary frequency		
Itchy eyes			Urgency (sudden urge to urinate)		
Sore throat					
Mouth sores or ulcers			Urine leaking		
Bleeding gums			Pain with urination		
Heart	√=Yes	√=No	Blood in urine		
Chest pain			Incomplete bladder emptying		
Irregular heart beat			Nighttime urination (>2/night)		
Ankle/foot swelling			**Musculoskeletal**	√=Yes	√=No
Lungs	√=Yes	√=No	Muscle or joint pain		
Shortness of breath			Body aches and stiffness		
Chronic cough			Leg pain		
Wheezing			Back pain		
Neurologic	√=Yes	√=No	**Endocrine**	√=Yes	√=No
Headaches			Excess hair growth		
Dizziness			Nipple discharge		
Memory loss			Hot flashes		
Low attention / difficulty concentrating			Night sweats		
			Changes in voice		

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Date