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# University Health OB/GYN

Gynecology Questionnaire

TMC TRUMAN MEDICAL CENTERS | Better. For Everyone.

Name _____ Date _____ Date of Birth* _____ Age _____

Race* _____ Ethnicity* _____ Primary Language* _____

*Required by Healthcare/Meaningful Use Legislation

Cell Phone _____ Home Phone _____ Work Phone _____

Preferred Pharmacy _____ Location _____ Phone# _____

**If English is not your primary language, do you need a translator? (please circle) YES NO**

**Well Woman Update (Please provide results & dates)** Primary Care Doctor & location _____

Last Pap smear _____(month/year)

Last mammogram _____(year)

Last colonoscopy _____(year)

Last bone density exam _____(year)

Last tetanus shot _____(year)

HPV/ Gardasil Vaccine series completed? ____ YES ___ NO

Have you had the Hepatitis B vaccine series? ___ YES ___ NO

Any abnormal Pap smears? _____YES_____NO

Cervical Dysplasia (precancerous cells of the cervix)?

_____YES_____NO

If yes, any treatment? Dates:

LEEP _____

Laser _____

Cryo (freezing) _____

Cone Biopsy _____

**Medical History: Do you now have or have you ever had:**

- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune disorder _____
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer _____
- ☐ Chicken pox/Shingles
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ Diabetes in Pregnancy
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Endometriosis
- ☐ Fibroids
- ☐ G.I. illness ____
- ☐ GERD/Reflux
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ HPV/genital warts
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pelvic inflamm. disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis

Other _____

_____

_____

_____

**Surgical History:** List ALL surgical procedures & year

_____

_____

_____

_____

_____

_____

_____

_____

**Anesthesia Complications:** Check those that apply

- ☐ Excessive difficulty waking up
- ☐ Difficult intubation
- ☐ Malignant Hyperthermia

**Medications & Allergies:** (attach list &/or bring bottles)

Current names & doses _____

_____

Vitamins/Supplements _____

Allergies/Reactions _____

**Family History:** If mother/father are deceased, list age. Please fill out the cancer questionnaire as well.

| ILLNESS | Mother | Father | Brother | Sister | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather | Other relative |
|---|---|---|---|---|---|---|---|---|---|
| Diabetes (type) | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| Osteoporosis | | | | | | | | | |
| Genetic Disease | | | | | | | | | |
| Other | | | | | | | | | |

**PLEASE COMPLETE BOTH SIDES**

**Reproductive History:** Menstrual Cycle

Age at first period? _____ If menopausal, age at menopause: _____

How often do you get your menstrual cycle? Every _____ days, lasting _____ days.

Are your periods painful? □ Severe □ Moderate □ Mild □ No

Are your cycles? □ Regular □ Irregular

Do you have sex with anyone? □ Yes □ No □ Never

□ Men □ Women □ Both

Method of birth control:

| | | | | |
|---|---|---|---|---|
| □ None | □ Vasectomy | □ Rhythm Method | □ Nexplanon | □ Tubal Ligation |
| □ Diaphragm | □ Condoms | □ NuvaRing | □ Mirena IUD | □ Essure |
| □ Pill _____ | □ Patch | □ Depo-Provera | □ ParaGard IUD | □ Other _____ |

**Obstetrical History**

Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birth date.

**Type**: vaginal, c-section, forceps, or vacuum **Anesthesia**: epidural, local, general, spinal

**Complications**: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression.

If preterm labor, were medications used?

| | Birth date | Weeks | Length of Labor | Baby's Weight | Sex | Type of Delivery | Anesthesia | Complications | Location |
|---|---|---|---|---|---|---|---|---|---|
| EXAMPLE: | 01/15/75 | 40 | 12hrs | 6 lb. 2 oz. | F | Vaginal | Epidural | HBP. Gest. Diabetes. | Truman |
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**Social History**

Occupation: _____

Are you? ☐ Married ☐ Single ☐ Engaged ☐ Significant other ☐ Divorced ☐ Widowed

Emergency Contact: _____ Phone# _____

Tobacco Use: □Never □Current_____# of Cigarettes per day □Former, Quit at age _____ □ Other_____

Any alcohol use? ☐ Yes ☐ No *If yes, the average number of drinks per week _____

Do you use street drugs? ☐ Yes ☐ No *If yes, the type used and last use _____

How many times and how long per week do you exercise? (circle) 1x 2x 3x 4x 5x+

Per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? ☐ Daily ☐ Some ☐ No

Any history of violence or abuse in your current household or in your past? □ Yes □ No

Do you wear your seatbelts in the car? □ Yes □ No Do you have smoke detectors at home? □ Yes □ No

Do you have any cultural or religious considerations that need special attention? □ Yes □ No

Patient Signature: _____ Date: _____

**PLEASE COMPLETE BOTH SIDES**