

University Health OB/GYN



Better. For Everyone.

Name	MATTER.			D	ate	Dat	onnaire e of Birth*	Age	!		
Required by Healthcare/Meaningful Use Legislation Cell Phone Home Phone Location Phone Phone	Race	*Ethnicity*					Primary Language*				
Careful Woman Update (Please provide results & dates)	*Required	by Health	care/Meanir	ngful Use	Legislati	on ,	0 0 _				
Careful Woman Update (Please provide results & dates)	Cell Phone		Hom	e Phone			Work Pho	one			
Last Pap smear	Preferred Pharmacy Location						Phone#				
Last Pap smear		If English	h is not your	primary	language	e, do you need	a translato	or? (please circle) YES NO		
Last mammogram	ell Woman Upda	ate (Please	provide <u>res</u>	ults & da	tes)	Primary Care D	octor & loc	cation			
Last mammogram	.ast Pap smear		(mo	nth/year)	Any abnor	mal Pap sm	nears?		YESNO	
						Cervical D					
Surgical History: List ALL surgical procedures & year Grandmother Grandfather Current names & doses Current names &										YESNO	
Last tetanus shot						If yes, a		ent? Dates:			
Anemia	•						LEEP				
Medical History: Do you now have or have you ever had: Anemia	ast tetanus shot		(year)				Laser				
Aanemia	IPV/ Gardasil Va	ccine series	s completed?	?Y	'ES N	10	Cryo (free:	zing)			
Anemia Depression/Anxiety Hepatitis C Liver Disease Asthma Diabetes in Herpes Migraines Osteoporosis Diabetes Type I High Blood Pressure Osteoporosis Diabetes Type II HIV disease Blood transfusion Endometriosis HPV/genital warts Seizures Blood transfusion Endometriosis Hyperthyroidism Seizures Blood transfusion Endometriosis Hyperthyroidism Stroke Cancer G.I. illness Hyperthyroidism Stroke Chicken pox/Shingles GERD/Reflux Infertility Syphilis Chlamydia Gonorrhea Irritable Bowel Syndrome Deep Vein Thrombosis Heart disease Hepatitis B 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 Naternal Grandmother Grandfather Grandfather Other relative Diabetes (type) Heart Disease Other Trains Paternal Grandfather Other relative Other relative Other relative Other relative	lave you had the	Hepatitis F	B vaccine ser	ies? '	YES N	10	Cone Biop				
Asthma	Лedical History:	Do you no	w have or h	ave you	ever had	:					
Asthma	☐ Anemia		Ε	Depre	ssion/Anx	riety	☐ He	patitis C	П	Liver Disease	
Autoimmune disorder	☐ Asthma					-			_		
Bleeding Disorder	☐ Autoimmun	e disorder		Pregna	ancy		☐ Hig	gh Blood Pressure		_	
Blood transfusion Endometriosis HPV/genital warts Seizures				Diabet	tes Type I		☐ Hig	gh cholesterol		Pelvic inflamm.	
Bone/Joint Disease	Bleeding Dis	order		Diabet	tes Type II	l		V		disease	
Bone/Joint Disease	☐ Blood transf	fusion		Endon	netriosis					Seizures	
Cancer	☐ Bone/Joint ſ	Disease		Fibroid	ds				П	Sleep Apnea	
Chicken pox/Shingles	☐ Cancer		Г	GLille	ness		-				
Chlamydia Gonorrhea Gonorrhea Irritable Bowel Syndrome Other Trauma Tuberculosis Deep Vein Thrombosis Heart disease Hepatitis B Syndrome Other Tuberculosis Dementia Heart disease Hepatitis B Syndrome Other Tuberculosis Dementia Heart disease Hepatitis B Syndrome Other Tuberculosis Dementia Tuberculosis Dementia Trauma Tuberculosis Dementia Heart disease Other Trauma Tuberculosis Difficult intubation: Malignant Hyperthermia Medications & Allergies: (attach list &/or bring bottles) Current names & doses Vitamins/Supplements Allergies/Reactions Vitamins/Supplements Maternal Paternal Maternal Paternal Grandfather Grandfather				_		_	-				
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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										
-	, ave sex with a	anyone?		_	No	□ Never				
□ Men □ Women □ Both										
Method of birth control:										
□ None	agm	□ Vase	ectomy	□ Rhytl □ Nuva			□ Nexplanon □ Mirena IUD	□ Tubal Ligation □ Essure		
□ Diaphr□ Pill	agiii			□ Nuva	_		□ Miliella 100 □ ParaGard IU			
	al History			•						
Please lis	st all pregnand	cies, <u>inclu</u>	ding misca	rriages, abortic	ns, an	ıd ectopic pr	egnancies. Pl	ease include <u>full birth date</u> .		
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	
Social Hi	story	l			l					
Occupati	on:									
Are you?	□ Married	☐ Sing	le 🗆 Eng	aged 🗆 Sign	ificant	other [☐ Divorced	□Widowed		
Emergen	cy Contact: _						Phone#_			
Tobacco	Use:	□Neve	r □Cu	rrent# of	Cigar	ettes per da	y □Former,	Quit at age Other		
Any alco Do you u	hol use? se street druរូ	gs?	□ Yes	□ No				of drinks per weekst use		
-		_	per week o	do you exercise				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 No No Yes No										
Patient Signature: Date: PLEASE COMPLETE BOTH SIDES										
Form# 90218 Date: 03/16 University Health OR/GVN Gynecology Questionnaire										

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