Airport-Playa Women's Medical Group
OB/GYN Questionnaire

NAME:_____ **DATE:** _____

DATE OF BIRTH: _____

REASON FOR VISIT: (If not routine, briefly describe main symptoms.) _____

PAST MEDICAL HISTORY:

List all operations you have had.

OPERATION	DATE
A _____	_____
B _____	_____
C _____	_____
D _____	_____
E _____	_____
F _____	_____

List all illnesses you have had that required hospitalization.

ILLNESS	DATE
A _____	_____
B _____	_____
C _____	_____
D _____	_____
E _____	_____
F _____	_____

Have you ever had? (Check yes or no and give dates.) Please list any additional medical conditions or illnesses:

YES	NO	ILLNESS	DATE
( )	( )	Migraine Headaches	_____
( )	( )	Thyroid Disorder	_____
( )	( )	Pneumonia	_____
( )	( )	Tuberculosis	_____
( )	( )	Heart Murmur	_____
( )	( )	High Blood Pressure	_____
( )	( )	Rheumatic Fever	_____
( )	( )	Diabetes	_____
( )	( )	German Measles or Vaccine	_____
( )	( )	Anemia	_____
( )	( )	Convulsions or Seizures	_____
( )	( )	Ulcers	_____

YES	NO	ILLNESS	DATE
( )	( )	Jaundice of Hepatitis	_____
( )	( )	Kidney Stones	_____
( )	( )	Kidney Infection	_____
( )	( )	Bladder Infection	_____
( )	( )	Genital Herpes	_____
( )	( )	Gonorrhea	_____
( )	( )	Syphilis	_____
( )	( )	Broken Bones	_____
( )	( )	Arthritis	_____
( )	( )	Mental Illness	_____
( )	( )	Serious Injury	_____
( )	( )	Blood Transfusion	_____

REVIEW OF SYSTEMS:

Are you currently having or have you recently had any of these symptoms? (Check "**YES**" or "**NO**")

A. GENERAL

YES	NO	
( )	( )	Recent weight gain
( )	( )	Recent weight loss
( )	( )	Depression
( )	( )	Eye pain
( )	( )	Spots in front of eyes
( )	( )	Double vision
( )	( )	Glasses
( )	( )	Deafness
( )	( )	Nose bleeds

B. CHEST AND HEART

YES	NO	
( )	( )	Palpitation
( )	( )	Skipped or irregular heart beats
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Shortness of breath lying down
( )	( )	Coughing up blood

C. BREASTS

YES	NO	
( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Breast cancer (Family)
( )	( )	Previous mammogram

Date: _____

D. GASTROINTESTINAL

YES	NO	
( )	( )	Change in bowel habits
( )	( )	Constipation
( )	( )	Diarrhea
( )	( )	Bright blood in stools
( )	( )	Clay colored stools
( )	( )	Black stools
( )	( )	Abdominal pain
( )	( )	Hemorrhoids
( )	( )	Vomiting up blood
( )	( )	Painful bowel movements
( )	( )	Nausea or vomiting

E. GENITO-URINARY

YES	NO	
( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Excessive urine
( )	( )	Frequent night urination
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine
( )	( )	Wetting in bed

F. EXTREMITIES

YES	NO	
( )	( )	Varicose veins
( )	( )	Leg pain when walking
( )	( )	Blood clots in legs
( )	( )	Skin rashes
( )	( )	New or growing moles

MEDICATIONS: (List **ALL** medications that you take regularly or have taken recently, include all non-prescription drugs.)

1. _____ 3. _____
2. _____ 4. _____

ALLERGIES: Are you allergic to any medications, drugs, chemicals or food? (If **YES**, list which ones)

_____

CONTRACEPTIVE HISTORY: (List present and previous history of birth control you have used.)

	METHOD TYPE	DURATION OF USE	COMPLICATIONS
PRESENT	_____	_____	_____
PREVIOUS	_____	_____	_____
	_____	_____	_____

OBSTETRIC HISTORY: (List all pregnancies, dates, and outcomes.)

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

FAMILY HISTORY: (List family members (father, mother, sister, brother) with any current health problems and their ages. Also list deceased family members, the cause of death and their ages at death_____

_____

_____

Have any other blood relatives had serious medical problems or inherited problems? Any children born in the family with an abnormality?_____

_____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? Yes No How many/day? _____ How many years?_____

Do you drink alcohol? Yes No How many drinks/day? _____ Per week? _____

Do you get any regular exercise? Yes No How often? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY

First day of last period: _____ Age first started period: _____ Number of days between periods: _____

Usual # of days of flow: _____ Are your periods: Light Moderate Heavy Cramps with periods? Yes No

Depression, anxiety, emotional upset before periods? Yes No Bleeding or spotting between cycles? Yes No

PAP SMEARS:

Last pelvic exam: _____ Last pap smear: _____

Have you ever had an abnormal pap? Yes No

If yes, what treatment was done? _____

Have your paps been normal since treatment? Yes No

Did your mother take hormones while pregnant with you? Yes No

VAGINITIS:

Yeast: _____ Trichomonas: _____ Non-specific/Bacterial Vaginitis: _____

Are you having any problem with discharge now? Yes No

SEXUAL HISTORY:

Any problems with pain? Yes No Any problem with Orgasm? Yes No Other? _____

Any history of STDs? HPV? Yes No Herpes? Yes No Syphilis? Yes No Hepatitis? Yes No

HIV? Yes No Gonorrhea? Yes No Chlamydia? Yes No Other? _____

List any Gynecologic surgeries, dates and reasons for surgery: _____

_____

_____