

Gyn Patient Health History Questionnaire

Please fill out this health history questionnaire thoroughly and specifically. It is important information which will enable us to spend more time discussing your medical condition.

Name: _____ DOB: _____ Age: _____ Date: _____

What is your current marital status? Single Married Divorced Widowed Engaged

Reason for today's visit/Problems to discuss with the doctor: _____

What surgeries have you had? Please be as specific as possible.

Month/Year	Surgery	Any Complications?

What medications are you currently taking? Please include vitamins and over-the-counter medications.

What medications are you allergic to? _____

What medical problems have you had in the past? Please explain specifically.

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Cholesterol Problems
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Anemia or Blood Disorders
<input type="checkbox"/> History of Blood Transfusions
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Asthma
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Lung Disorders
<input type="checkbox"/> Stomach or Bowel Disorders
<input type="checkbox"/> Other problems: | <input type="checkbox"/> Hepatitis or Liver Disorders
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Seizures
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Depression or Psychiatric Disorders
<input type="checkbox"/> Cancer
<input type="checkbox"/> Birth Defects
<input type="checkbox"/> Anesthesia Complications
<input type="checkbox"/> Infertility
<input type="checkbox"/> Abnormal Pap Smear |
|--|--|

Gynecological History

When was your last Pap Smear? _____ Was it normal? Yes No

Have you ever had any abnormal pap smears or precancerous results? Yes No

Do you still have periods? _____ If not, at what age did they stop? _____ Why? Menopause Surgery Other

When was the first day of your last period? _____ Was it normal? Yes No

How old were you when you began having periods? _____ How often do you have periods? _____

How long do they last? _____ Are they painful? Yes No How many days are painful? _____

Do you have problems with your bladder? Leakage Urgency Frequency Burning

Do you check your breasts for lumps? Yes No How often? _____ Have you found any? Yes No

Name: _____ DOB: _____

Do you drink alcohol? Yes No If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

SCORE _____

Have you ever experimented with recreational or prescription drugs? Yes No If yes, please answer the following questions:

Have you ever felt you ought to cut down on your drug use? Yes No

Have people annoyed you by criticizing your drug use? Yes No

Have you ever felt bad or guilty about your drug use? Yes No

Have you ever used drugs first thing in the morning to steady your nerves? Yes No

SCORE _____

Depression Screening

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns _____ + _____ + _____
TOTAL _____