CULLMAN REGIONAL
Gynecology Clinic

Gynecology Questionnaire

Signature OB/GYN

Name _____ Date: _____ Date of Birth* _____
Age _____ Race* _____ Ethnicity* _____ Primary Language* _____
Pharmacy _____ *Required by Healthcare/Meaningful Use Legislation.
Reason for Today's Visit: _____

Medicines & Allergies:
Current medications & dosage

_____
_____
_____
_____

Drug Allergies: _____
_____
_____

Please list any hormones or birth control you are taking:

_____
_____
_____

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

- ☐ Asthma
- ☐ Autoimmune disorder _____
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer (type?) _____
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Elevated cholesterol
- ☐ Endometriosis
- ☐ Fibroids (type?)
- ☐ GERD/Reflux
- ☐ G.I. illness _____
- ☐ Gestational Diabetes
- ☐ Gonorrhea _____
- ☐ Heart disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ HIV
- ☐ HPV/genital warts
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pelvic inflamm. disease
- ☐ Pain/Burning/ Frequency with Urination
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis
- ☐ Trichomonas

Other: _____

Surgical History: Please list ALL surgical procedures, including year:

_____
_____
_____
_____
_____
_____
_____

Please check if you have had any of the following:

- ☐ Total Abdominal Hysterectomy
- ☐ Total Vaginal Hysterectomy
- ☐ Laparoscopic Supracervical Hysterectomy
- ☐ Robotic-Assisted Total Hysterectomy
- ☐ Bilateral Salpingo Oophorectomy (both tubes & ovaries removed)
- ☐ Left Salpingo Oophorectomy (left tube & ovary removed)
- ☐ Right Salpingo Oophorectomy (right tube & ovary removed)

PLEASE COMPLETE BOTH SIDES

Well Woman Update: (Please provide dates where applicable) Primary Care Provider (Doctor): _____

Last bone density exam _____(year)
Last colonoscopy_____(year)
Last mammogram _____(year) Location _____
Last Pap smear_____(month/year)

Traveled out of country in last month? ___ YES __ NO
HPV/ Gardasil Vaccine series completed? ___ YES __ NO
Have you had the Hepatitis B 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 _____

Family History: Include the age of onset and type of cancer.

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

Social History
Occupation:_____

Are you? Married Single Engaged Significant other Divorced Widowed Same Sex Partner

Tobacco Use: ☐ Never ☐ Current___ # of Cigarettes per day ☐ Former, Quit at age ____

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 _____

Any history of violence or abuse in your current household or in your past? **YES** _____ **NO** _____

Do you have any cultural or religious considerations that need special attention? **YES** _____ **NO** _____

Reproductive History: Menstrual Cycle
Age at first period? _____ If menopausal, age of menopause: _____ **First day** of last period: _____

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

Are your cycles? ☐ Regular ☐ Irregular
Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Method of contraception:

☐ Not Needed	☐ Vasectomy	☐ Rhythm Method	☐ Nexplanon	☐ Tubal Ligation
☐ None	☐ Condoms	☐ NuvaRing	☐ Liletta IUD	☐ Essure
☐ Pill	☐ Patch	☐ Depo Provera	☐ ParaGuard IUD	☐ Ablation

Other _____

Obstetrical History
Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal, C/S, forceps, or vacuum

PAST PREGNANCIES

	Birthdate	Weeks	Type of delivery
EXAMPLE:	01/15/75	40	Vaginal

*****Subject to the needs of your health, a scheduled appointment may be changed by the provider to a different type of appointment.** _____ (Please Initial)

Patient signature_____ Date: _____

PLEASE COMPLETE BOTH SIDES

Last Update: March 28, 2019