New England OB-GYN Health Questionnaire and History

Patient Name:____ **DOB:** ___________________

Physician Name: ______________________________________ **Date:** ___________________

Main reason for visit today:

☐ Annual (Please continue to patient history p.2)
☐ Problem (Please complete problem portion p.1 and patient history)
☐ Follow-up (Please complete follow-up portion p.1 and patient history)

Problem Appointment Only - Chief Complaint:

Please describe the problem:

___

On a scale of 1-10, with 10 being the most severe, circle the number that best describes this problem:

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

___

Does anything help or make the problem worse?

___

How long does the problem last?

___

Is anything else occurring at the same time?

___

Is the problem constant or variable?

___

Does the problem interfere with your daily functions?

☐ Yes ☐ No Explain:

___

Follow-up Appointment Only

Please indicate the reason for your appointment today or what you would like to discuss with your provider:

___

___

PATIENT HISTORY

PERSONAL SAFETY

We routinely ask patients about their safety because abuse can have a serious impact on health and well-being.

No Current Partner ☐ Decline ☐

Are you currently or in the past 12 months have you been in a relationship with a person who physically hurts, threatens, or tries to control you?

Yes ☐ No ☐

Has anyone else in your life physically hurt, threatened or tries to control you? Yes ☐ No ☐

Are you denied basic needs such as food, clothing, or medical care? Yes ☐ No ☐

MEDICARE "HIGH RISK" CRITERIA: Please check (√) if you have ever been treated for any of the following infections:

Vaginosis/BV	☐	Genital Warts	☐	Chlamydia	☐
Trichomonas	☐	Gonorrhea	☐	Syphilis	☐

	YES	NO	
Did your mother take the drug DES when she was pregnant with you?	☐	☐	
Have you ever had an abnormal Pap smear test?	☐	☐	If so, when? ______________
Did you begin sexual activity before you were 16 years old?	☐	☐	
Have you had more than 5 sexual partners in your lifetime?	☐	☐	
Have you ever tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	
Have you had a Pap smear in the last 7 years?	☐	☐	

PATIENT HISTORY
MENSTRUAL HISTORY

Age of Menstrual Onset

____

Last Menstrual Period

____

Period Pattern
- ☐ Normal
- ☐ Irregular

Menstrual Flow
- ☐ Light
- ☐ Moderate
- ☐ Heavy

Menstrual Pain
- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe

OBSTETRICAL HISTORY

Pregnancies: ________________

Miscarriages:________________

Live births: ________________

Vag Deliveries:______________

C-Sections: ________________

Pregnancy Complications

____

____

MEDICAL HISTORY
- ☐ Abnormal Pap
- ☐ Abnormal uterine bleeding
- ☐ Anemia
- ☐ Anesthetic Complications
- ☐ Asthma
- ☐ Bacterial vaginosis
- ☐ Breast cancer
- ☐ Breast mass
- ☐ Cervical cancer
- ☐ Chlamydia
- ☐ Condyloma
- ☐ Diabetes Mellitus
- ☐ Ectopic Pregnancy
- ☐ Endometrial Cancer
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Gonorrhea
- ☐ Herpes
- ☐ HPV infection
- ☐ Hypertension
- ☐ Infertility
- ☐ Menopause
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Ovarian cancer
- ☐ Ovarian cyst
- ☐ Polycystic ovary syndrome
- ☐ STD
- ☐ Syphillis

- ☐ Thrombophillia
- ☐ Thyroid disease
- ☐ Urinary incontinence
- ☐ UTI

SURGICAL HISTORY

- ☐ Appendectomy
- ☐ Bladder suspension
- ☐ Breast biopsy
- ☐ Breast lumpectomy
- ☐ Cholecystectomy
- ☐ Colporrhaphy
- ☐ Colposcopy
- ☐ Cone biopsy
- ☐ C-Section
- ☐ Cystocele repair
- ☐ Dilation and Curettage (D&C)
- ☐ Dilation and Evacuation (D&E)
- ☐ Endometrial ablation
- ☐ Exploratory laparotomy
- ☐ Genital wart removal
- ☐ Gynecologic cryosurgery
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Laser conization
- ☐ LEEP
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Ovary removal
- ☐ Tubal ligation
- ☐ Weight loss surgery

FAMILY HISTORY

Significant family history/conditions

____

____

First Degree Relatives

Mother

☐ Living ☐ Deceased

Significant health history:

____

Father

☐ Living ☐ Deceased

Significant health history:

____

Sibling(s)

☐ Living ☐ Deceased

Significant health history:

____

SOCIAL HISTORY

- ☐ Alcohol (amount/drinks per week) ________________________
- ☐ Tobacco (amount/packs per day/Year quit) ________________________
- ☐ Drugs (past or present) ________________________

Are you sexually active?

☐ Yes ☐ No

Birth control method:

____

Sexual Partners

- ☐ Sex with men
- ☐ Sex with women
- ☐ Sex with men & women

Sexual Concerns

- ☐ Pain with intercourse
- ☐ No sex drive
- ☐ Bleeding with sex
- ☐ Other:____________________

PREVENTATIVE TESTS

Date of last Pap Smear:

____

Date of last mammogram:

____

Date of last bone density:

____

Date of last colonoscopy

____

Exercise Regularly?

☐ Yes ☐ No

Caffeine Use?

☐ Yes ☐ No

Well Balance Diet?

☐ Yes ☐ No

Seatbelt Use?

☐ Yes ☐ No

Sun exposure?

☐ Yes ☐ No

REVIEW OF SYSTEMS

Check all that apply

General

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change
- ☐ No complaints

Head/ Ears/Neck/Throat

- ☐ Ringing in the ears
- ☐ Neck pain
- ☐ No complaints

Eyes

- ☐ Visual disturbances
- ☐ No complaints

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ No complaints

Cardiovascular

- ☐ Chest pain
- ☐ Leg swelling
- ☐ No complaints

Gastrointestinal

- ☐ Abdominal bloating
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea

- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting
- ☐ No complaints

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ No complaints

Genital/Urinary
- ☐ Difficulty urinating
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Involuntary urination
- ☐ Flank pain
- ☐ Frequency (more than 8x/day)
- ☐ Genital sore
- ☐ Blood in urine
- ☐ Incontinence (urinary)
- ☐ Menstrual problems
- ☐ Pelvic pain
- ☐ Urgency
- ☐ Decreased urine output
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ No complaints

Musculoskeletal
- ☐ Back pain
- ☐ Joint swelling
- ☐ No complaints

Skin
- ☐ Rash
- ☐ No complaints

Allergic/Immunologic
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ No complaints

Neurological
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ No complaints

Mental Health
- ☐ Sad/depressed
- ☐ Nervous/anxious
- ☐ Trouble sleeping
- ☐ No complaints

Allergies (Food/drug/environmental) Reaction (Hives, swelling, etc)

____

____

____

Current Medications Dose Prescribed by

____

____

____

____

____

____

____

Physician Signature Date

____

Patient Signature Date