New England OB-GYN Health Questionnaire and History

Patient Name: _____ DOB: _____

Physician Name: _____ Date: _____

Main reason for visit today: ☐ Annual ☐ Problem

Section 1 (Problem Visit 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:

ALL PATIENTS COMPLETE THE FOLLOWING SECTIONS

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

Current Partner(s) ☐ 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:

Vaginos	☐	Genital	☐	Chlamydia	☐
Tricho	☐	Gonorr	☐	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, _____
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 AIDS/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
- ☐ Other

_____

SURGICAL HISTORY
- ☐ Appendectomy
- ☐ Bladder suspension
- ☐ Breast biopsy
- ☐ Breast lumpectomy
- ☐ Breast reconstruction
- ☐ Breast reduction
- ☐ 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
- ☐ Other

_____

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