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 (v) if you have ever been treated for any of the following infections:

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<th>Vaginos</th>
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<th>Chlamydia</th>
<th>Syphilis</th>
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Did your mother take the drug DES when she was pregnant with you?

Have you ever had an abnormal Pap smear test?

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

□ Normal

□ Irregular

Last Menstrual Period

□ Normal

□ Irregular

Period Pattern

□ Light

□ Moderate

□ Heavy

Menstrual Flow

□ None

□ Mild

□ Moderate

□ Severe

Menstrual Pain

□ None

□ Mild

□ Moderate

□ Severe

OBSTETRICAL HISTORY

Pregnancies: ________________

Miscarriages: ________________

Live births: ________________

Vag Deliveries: ________________

C-Sections: ________________

Pregnancy Complications

□ Appendectomy

□ Bladder suspension

□ Breast biopsy

□ Breast lumpectomy

□ Breast reconstruction

□ Breast reduction

□ Cholecystectomy

□ Colporrhaphy

□ Colposcopy

SURGICAL HISTORY

□ Abnormal Pap

□ Abnormal uterine bleeding

□ Anemia

□ 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

□ Syphilis

□ Thrombophillia

□ Thyroid disease

□ Urinary incontinence

□ UTI

□ Other

□ Anesthetic Complications

□ 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

□ Myectomy

□ 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)

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<th>Allergies</th>
<th>Reaction (Hives, swelling, etc)</th>
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### Current Medications

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**Physician Signature**

**Date**

**Patient Signature**

**Date**