

**Gynecology Patient Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

**Allergies to medicines:** No Yes - to: \_\_\_\_\_ Reaction: \_\_\_\_\_

**Allergies to latex:** No Yes Reaction: \_\_\_\_\_ **Noted on patient chart**

**Medications / Herbs** taken daily: \_\_\_\_\_

Reason for today's visit: Annual Exam Birth control Other: \_\_\_\_\_

|   |  |           |   |                                  |
|---|--|-----------|---|----------------------------------|
| S | Occupation:  | Homemaker | Student   | Other: _____                     |
| O | Marital Status:  | Married   | Single  | Divorced Live in Partner Widowed |
| C | Exercise:  | No        | Yes - How many times a week? _____ for _____ (# of minutes) |                                  |
| I | Do you smoke?  | No        | Yes - Amount per day _____ for _____ (# of years).          |                                  |
| A | Do you want help to quit smoking?                                      | No        | Yes   |                                  |
| L | Do you drink?  | No        | Yes - # of drinks/week _____ Type of alcohol _____          |                                  |
|   | Are you concerned about the amount you drink or use?                   | No        | Yes   |                                  |
|   | Do you use recreational drugs?   | No        | Yes - What kind? _____ How often? _____                     |                                  |
|   | Have you ever used needles to inject drugs not prescribed by a doctor? | No        | Yes   |                                  |
|   | Are you safe in your current relationship or home?                     | No        | Yes   |                                  |

Provider Comments:

|   |                 |   |
|---|-----------------|---|
| Name of your family doctor or provider: _____ |                 | I Don't have one                        |
| <b>Now</b>                                    | <b>Previous</b> | <b>MEDICAL PROBLEMS</b>                 |
| M   | •               | Anemia or blood disorders               |
| E   | •               | Asthma or respiratory problems          |
| D   | •               | Bladder / kidney infections or stones   |
| I   | •               | Cancer: Type _____                      |
| C   | •               | Diabetes                                |
| A   | •               | Headaches or Migraines                  |
| L   | •               | High Blood Pressure                     |
|   | •               | Seizures                                |
|   | •               | Thyroid problems low or high            |
|   | •               | Other: _____                            |
|   | •               | Surgery: Date & Type: 1) _____ 2) _____ |
|   |                 | 3) _____ 4) _____                       |

Provider Comments:

**(OVER)**

