West Florida Medical Group

West Florida Obstetrics and Gynecology

PATIENT HISTORY QUESTIONNAIRE

Date: _____

A PAP SMEAR/MAMMOGRAM HISTORY

1. ❑ Date of last pap smear: _____
2. ❑ Have you had abnormal pap smears? ❑ No ❑ Yes
3. ❑ Have you had treatment for abnormal pap smears? No ❑ Yes ❑

   If yes, what type(s) of treatment have you had?

   ❑ cryotherapy _____(year) ❑ laser _____(year) ❑ cone biopsy _____(year) ❑ loop excision (LEEP) _____(year)
4. Date of last mammogram: _____ (MONTH) _____ (YEAR)
5. Have you had an abnormal mammogram? No ❑ Yes ❑

MENSTRUAL HISTORY

6. Age at first period: _____ years. Date of last period: _____
7. If your menstrual periods are regular; periods start every:_____ days
8. If your menstrual are irregular; periods start every:_____ to _____ days (e.g., 12 to 60)
9. Duration of bleeding: _____ days
10. Is pain associated with periods? Yes ❑ No ❑ Occasionally ❑
11. If yes to 16, is it: before menses? ❑ during menses? ❑ both? ❑

DO YOU HAVE A HISTORY OF -

12. Check any that apply: ❑ None ❑ Venereal warts ❑ Herpes - genital ❑ Syphilis
    ❑ Pelvic inflammatory disease ❑ Endometriosis ❑ Chlamydia ❑ Gonorrhea
    ❑ Vaginal infections ❑ Other _____
    ❑ Trichomoniasis ❑ PCOS
13. Last Dexascan _____ Last Colonoscopy _____

B PREGNANCY HISTORY (all pregnancies)

Have never been pregnant ❑

14. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

						CHILD		
Delivery Date	Place of delivery or Abortion	Weeks at Delivery	Hrs. of Labor	Type of Delivery	Complications Mother and/or infant	Sex	Birth Weight	Present Health

C SURGICAL HISTORY

15. Check any that apply: or ❑ None

SURGERY	YEAR	SURGERY	YEAR
❑ D&C		❑ tubal surgery	
❑ hysteroscopy		❑ L cyst(s) removed ovarian	
❑ infertility surgery		❑ R cyst(s) removed ovarian	
❑ laparoscopy		❑ L ovary removed	
❑ hysterectomy (vaginal, robotic or laparoscopic)		❑ R ovary removed	
❑ hysteroscopy (abdominal)		❑ vaginal or bladder repair	
❑ myomectomy		❑ incontinence (sling)	

PAST SURGICAL HISTORY (Not OB/GYN)

16. List all surgeries and the date performed or ❑ None

Surgeries	Year

D BIRTH CONTROL HISTORY

17. What birth control method(s) do you currently use?_____

E SEXUAL HISTORY

18. Do you have a sexual partner? No ❑ Yes ❑ (Male ❑ Female ❑) Both ❑

F PAST MEDICAL HISTORY Check any that apply: or ❑ None

- ❑ Diabetes
  - ❑ Diet controlled
  - ❑ Pill controlled
  - ❑ Insulin controlled
- ❑ High blood pressure
- ❑ Heart disease
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Gallstones
- ❑ Liver Disease (including hepatitis)
- ❑ Epilepsy
- ❑ Blood Transfusions
- ❑ Thyroid disease
- ❑ Asthma
- ❑ COPD
- ❑ HIV+
- ❑ Eating Disorder
- ❑ Blood clots
- ❑ Bleeding disorder
- ❑ Depression
- ❑ Anxiety
- ❑ Other

G CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

H SOCIAL HISTORY

19. Smoke No ❑ Yes ❑ ___packs/day ❑ Never smoked
20. Use alcohol No ❑ Yes ❑ ___wine (glasses/day); ___beer (bottles/day); ___hard liquor (oz./day)
21. Use illicit drugs No ❑ Yes ❑ If yes, Type:_____ Amount:_____
22. Exercise: Type:_____ How often:_____

I DRUG ALLERGIES

23. ❑ Are you allergic to any medications, antibiotics, or have a latex reaction?
24. No ❑ Yes ❑ list:

_____

_____

_____

J FAMILY HISTORY

❑ Pancreatic Cancer ❑ Prostate Cancer ❑ Breast Cancer ❑ Blood Clots
❑ Ovarian Cancer ❑ Endometrial Cancer ❑ Colon Cancer ❑ Bleeding Disorder
❑ Cystic Fibrosis ❑ Neural Tube Defect (Spinal Bifida) ❑ Other _____

If “yes” to any, please list affected relatives and age at diagnosis

_____

_____

_____