Medford WOMEN'S CLINIC LLP
obstetrics and gynecology

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GYN QUESTIONNAIRE

GENERAL INFORMATION

Name: ____ Preferred name: ______________ Date: _____________
Primary phone number: ______________________ DOB: _________ Age: ____ PCP: _____________
Home address (city/state/zip): ____
Occupation: _______________________________ Relationship status: ______________________________
Emergency contact (name/relationship/number): ____
Pharmacy preference: _____________________ Referred by: _______________________________________
Reason for visit: ____

OB & GYN HISTORY

Menses: Last menstrual cycle _______ ❑ Menopause ❑ Hysterectomy ❑ Hormone replacement use

Screening: Last pap smear (date/location):____________ ❑ History abnormal paps: ________________
❑ Normal ❑ Abnormal ❑ Prior LEEP/cone
Last mammogram: _____ Last colonoscopy: _____

Sexual history: Sexually active: ❑ Yes ❑ No Partners: ❑ Male ❑ Female Number in last year _____

Contraception: ❑ Pills ❑ IUD ❑ Nexplanon ❑ Depo ❑ Patch ❑ Trying for pregnancy ❑ Abstinence
❑ Condoms ❑ Natural family planning ❑ Tubal ❑ Vasectomy ❑ Menopause ❑ Nuvaring

Past infections: ❑ Chlamydia ❑ Gonorrhea ❑ Genital herpes ❑ Trichomonas ❑ Syphilis ❑ HIV ❑ HPV

Gyn history: ❑ Infertility ❑ PCOS ❑ Endometriosis ❑ Pelvic inflammatory disease ❑ Ovarian cysts
❑ Uterine fibroids ❑ Heavy menstrual bleeding ❑ Other ______________________________

Pregnancies: Total # ____ Vaginal: ____ Cesarean: ____ Miscarriages: ____ Ectopics: _____

MEDICAL & SURGICAL HISTORY

❑ Diabetes (type 1 or 2)	❑ Asthma	❑ Anxiety/depression	❑ Cancer
❑ High blood pressure	❑ Lung disease	❑ Seizure disorder	❑ Anemia
❑ Heart disease	❑ Thyroid disease	❑ Arthritis or lupus	❑ Blood transfusion
❑ Blood clotting disorder (DVT, PE)	❑ Kidney disease	❑ Stroke	❑ Migraines
❑ Bleeding disorder	❑ Cancer	❑ Anesthetic complications	*Aura? - Yes No*

❑ Hospitalizations or major illnesses: ____
____
____

❑ Cesarean section	❑ Hysterectomy	❑ Hysteroscopy	❑ D&C	❑ LEEP/ conization
❑ Laparoscopy	❑ Tubal sterilization	❑ Ovarian cyst	❑ Breast surgery	❑ Appendectomy

❑ Other: ____
____

MEDICATIONS (including over-the counter supplements and vitamins): ______________________________
____

____
____
Drug allergies/reaction: ____

Latex allergy: ❑ Yes ❑ No Shellfish allergy: ❑ Yes ❑ No

VACCINE HISTORY: Last flu vaccine ______________ Last Covid vaccine ___________
Gardasil (HPV) vaccine __________ Last tetanus vaccine __________

SOCIAL HISTORY

❑ Current nicotine – cig/vape(amount/day) ____________ ❑ Former smoker (date last use) _________________
❑ Current alcohol use ___________________ ❑ Prior alcohol use (avg drinks/week) ______________
❑ Recreational drug use (MJ, cocaine, opioid, meth, other): ____
Date of last use ______________ History IV drug use: ❑ Yes ❑ No
Exercise (type/frequency): ____
Hobbies: ____
Do you feel safe at home: ❑ Yes ❑ No ____

FAMILY HISTORY

	Age	General health, major health problems, OR cause of death
Mother		
Father		
Siblings		

Check if any of these illnesses run in the family:
❑ Breast cancer
❑ Ovarian cancer
❑ Colon cancer
❑ High blood pressure
❑ Diabetes
❑ Blood clotting (DVT/PE)
❑ Anesthetic complication
❑ Stroke
❑ Osteoporosis

REVIEW OF SYSTEMS (Check if positive within last month):

GENERAL	❑ Weight change	❑ Night sweats	❑ Loss of energy	❑ Trouble sleeping
SKIN	❑ Rashes	❑ Mole changes		
BLOOD	❑ Easy bruising	❑ Transfusions		
HEAD/NECK	❑ Hearing loss	❑ Sore throat	❑ Sinus pain	
BREASTS	❑ Lumps	❑ Nipple discharge	❑ Breast pain	
CARDIOVASCULAR	❑ Chest pain	❑ Leg swelling	❑ Palpitations	
PUMONARY	❑ Wheezing	❑ Shortness of breath		
GASTROINTESTINAL	❑ Nausea	❑ Poor appetite	❑ Abdominal pain	❑ Bloating/fullness
GENITOURINARY	❑ Bloody urine	❑ Burning on urination	❑ Pelvic pain	❑ Incontinence
	❑ Abnl discharge	❑ Other:		
SKELETAL	❑ Arthritis	❑ Fractures		
NEURO	❑ Headaches	❑ Dizziness	❑ Blackouts	
PYSCH	❑ Anxiety	❑ Depression	❑ PTSD	