MR#_____
DOB _____

Nurse-Midwifery Faculty Practice
Gynecologic Patient Questionnaire

Name:_____ Race/Ethnicity: _____

Email address: _____

Who referred you to our practice? _____

Occupation/Employer: _____

Relationship status: ☐single ☐married ☐divorced ☐separated ☐partnered ☐other

Medication allergies: _____

Current Medications/Dosages: _____

Previous surgeries: _____

What are your concerns today? Please check all that apply.

☐Check-up ☐Birth control ☐Breast changes ☐STD concern ☐Irregular menses

☐Menopause ☐Vaginal discharge ☐Sexual concerns ☐Planning pregnancy

☐Other: _____

Non-GYN concerns? _____

Patient Health History

Do you smoke? ☐No ☐Yes If yes, how much? _____ Are you interested in quitting? ☐No ☐Yes

Have you ever smoked? ☐No ☐Yes If yes, quit month/year? _____

Do you drink alcohol? ☐No ☐Yes If yes, how much and how often? _____

Current drug use? ☐No ☐Yes, drug(s):_____ In the past? ☐No ☐Yes, drug(s): _____

Regular Exercise? ☐No ☐Yes, How often? _____ Type of exercise? _____

Special diet? ☐No ☐Vegetarian ☐Vegan ☐Other:_____

Do you have: ☐unexplained weight loss or gain? ☐weight concerns? ☐current/past eating disorder?

Immunizations: check if current/immune ☐Tetanus/pertussis ☐Chicken pox ☐Rubella ☐Influenza

1st day of last menstrual period:_____ or ☐ post-menopausal ☐ post-hysterectomy ☐ hormonal suppression*****

*******hormonal suppression = no menses due to breastfeeding, birth control pills, Depo-Provera, IUD, etc.*

Age at first menstrual period: _____ Frequency: every_____ days Periods are ☐ regular ☐irregular

Discomfort: ☐ none ☐ minimum ☐ moderate ☐ severe Recent changes? Please describe: _____
When was your last pap smear? _____

History of abnormal pap smears? ☐ No ☐ Yes, When?_____ Treatment? _____
When was your last mammogram?_____ Colonoscopy? _____ Bone density scan? _____

Number of total pregnancies? _____ Pregnancy losses/terminations? _____ Living children? _____

Are you currently sexually active? ☐ Yes ☐ No If yes, ☐ with men ☐ with women ☐ with both

Lifetime # of sexual partners: ☐ Fewer than 5 ☐ 5 or more Do you desire STD testing today? ☐ No ☐ Yes

Have you ever been treated for an STD? ☐ No ☐ Yes, _____

Because abuse is an enormous problem among women, we ask all of our patients about a history of or present abuse so we may best meet your needs as your care provider.

Do you have any history of abuse? ☐Yes ☐No ☐I'm not sure. ☐I prefer not to answer.

If yes, please check all that apply: ☐Emotional ☐Physical ☐Sexual ☐Verbal ☐Spiritual ☐Other_____

☐I prefer to discuss this in more detail with my midwife. ☐I do not want to talk about this during my visit today.

Personal and Family Medical History

	Personal History		**Family History, Please indicate relative with disease history.**	
Cancer				
High Blood Pressure				
Heart Disease				
Lung Disease				
Gastrointestinal Problems				
Breast Disease				
Urinary Tract Problems				
Endocrine/Metabolic (Diabetes/Thyroid)				
GYN Problems				
Infertility/Miscarriages				
Sexually Transmitted Diseases/Infections	☐Herpes	☐HPV	☐Herpes	☐HPV
	☐Gonorrhea	☐Herpes	☐Gonorrhea	☐Herpes
	☐Chlamydia	☐Syphilis	☐Chlamydia	☐Syphilis
	☐HIV/AIDS	☐Other	☐HIV/AIDS	☐Other
Neurological Problems				
Psychiatric/Mental Illness	☐Depression	☐Anxiety	☐Depression	☐Anxiety
	☐Bipolar	☐Other	☐Bipolar	☐Other
Immunologic/Infectious Disease				
Hematologic Disease				
Other (please identify)				