**OB/GYN HISTORY AND PHYSICAL QUESTIONNAIRE**

**(The following comprehensive questions regarding your home environment, work environment and personal history are asked in compliance with the national guidelines for wellness exams.)**

**Gynecologic History:**

First Day of last menstrual period: \_\_\_\_\_\_\_\_\_

Age Periods began: \_\_\_\_\_\_\_\_\_

Postmenopausal: Yes/ No If yes at what age did your periods stop: \_\_\_\_\_\_

Any bleeding since: Yes/ No

How many days between cycles: \_\_\_\_\_\_\_\_\_\_

Do you have regular cycles: Yes/ No If no, than why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually Active: Yes/ Not Currently/ Never

If yes than at what age was first intercourse: \_\_\_\_\_

Partners: Male/ Female/ Both Any new partners in the last year: Yes/ No

Present Birth Control Method (including sterilization): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_ Last Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Abnormal pap: Yes/ No History of STI’s: Yes/ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy/Birth History:**

Pregnancies: \_\_\_\_\_\_ Live Births: \_\_\_\_\_\_ Full Term Deliveries: \_\_\_\_\_\_

Miscarriage: \_\_\_\_\_\_ Ectopic: \_\_\_\_\_\_ Pre-Term Deliveries: \_\_\_\_\_\_

Abortions: \_\_\_\_\_\_ Twins: \_\_\_\_\_\_

**Have you ever had the following with pregnancy**? **(circle all that apply)**

Hemorrhage Shoulder Dystocia Diabetes High Blood Pressure Fetal Injury

C-Section Pre-eclampsia Still Birth Special Needs Child Vacuum

Forceps Infant Death 3rd or 4th degree laceration

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Current occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship status: Single Married Living with Partner Divorced Widowed

Have you suffered from abuse? Yes / No If yes was it: Sexual Physical Emotional

Are you safe currently? Yes / No

Do you need assistance with mental health resources: Yes / No

**OB/GYN History and Physical Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What pharmacy do you use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for your visit today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS: (PLEASE CIRCLE IF YOU HAVE HAD ANY OF THESE IN THE PAST 30 DAYS)**

**GENERAL:** **GENITOURINARY:**

Chills Difficulty with urination

Fever Pain with intercourse

Hot Flashes Pain with urination

Weight changes Frequency of urination

 Blood in urine

**HEAD AND NECK:**  Loss of urine with cough or sneeze

Hearing Loss Loss of urine from not getting to restroom

 Problems with periods

**EYES:** Pelvic pain

Visual Disturbance Feeling the need to urinate urgently

 Abnormal vaginal bleeding

**RESPIRATORY:** Excessive vaginalbleeding

Shortness of breath Vaginal pain

**CARDIOVASCULAR:** **SKIN AND BREAST:**

Chest Pain Skin changes

 Hair changes

**GI:** Breast mass

Abdominal Bloating Breast pain

Abdominal Pain

Blood in stool  **NEURO:**

Changes in bowels Headaches

Fecal Incontinence (leakage of stool)

 **PSYCH:**

**ENDOCRINE:** Mood changes

Cold Intolerance Suicidal thoughts

Heat Intolerance

Night Sweats

**OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**