Dr. Felicia Donald, MD. OB/GYN FACOG

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www.forwomenobgyn.com

for women OB/GYN associates

A PATIENT HISTORY QUESTIONNAIRE

1. Marital Status: ☐ Single ☐ Married ☐ Long term Relationship ☐ Divorced ☐ Widow
2. Reason for this visit:_____
3. Referring Physician:_____
4. Occupation:_____
5. Preferred phone #:_____ Confidential voicemails OK: ☐Yes ☐No
6. Partner:_____ ☐ None 7. Age of partner:_____
   Last First

B MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

8. Age at first period:_____years.
9. If menstrual periods are regular; periods start every:_____days
10. If menstrual periods are irregular; periods start every:_____ to ____ days(e.g., 12 to 60)
11. Duration of bleeding _____days
12. Does bleeding or spotting occur between periods? Yes ☐ No ☐
13. Does bleeding or spotting occur after intercouse? Yes ☐ No ☐
14. First day of last menstrual period _____
    Month / Day / Year
15. Is pain associated with periods? Yes ☐ No ☐ Occasionally ☐
16. If yes to 15, is it: before menses? ☐ During mended? ☐ Both? ☐

C PREGNANCY HISTORY (All pregnancies) **Have never been pregnant ☐**

17. OBSTETICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (Tubal) PREGNANCIES

						CHILD		
YEAR	Place of delivery or Abortion	Duration Preg.	Hrs. of Labor	Type of Delivery	Complications Mother and/or Infant	Sex	Birth Weight	Present Health

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D BIRTH CONTROL HISTORY

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

E SEXUAL HISTORY

19. Do you have a sexual partner? No ☐ Yes ☐ (Male ☐ Female ☐)
20. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes ☐ No ☐

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

21. Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR
☐ D&C		☐ ovarian surgery	
☐ hysteroscopy		☐ L cyst(s) removed ovarian	
☐ infertility surgery		☐ R cyst(s) removed ovarian	
☐ tuboplasty		☐ L ovary removed	
☐ tubal ligation		☐ R ovary removed	
☐ laparoscopy		☐ Vaginal or bladder repair for prolapsed or incontinence	
☐ hysterectomy (vaginal)		☐ cesarean section	
☐ hysterectomy (abdominal)		☐ other (specify)	
☐ myomectomy		_____	

G PAST SURGICAL HISTORY (Not OB/GYN)

22. List all surgeries and their year or ☐ None

Surgeries	Year
_____	_____

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_____

_____

_____ _____

H PAP SMEAR/MAMMOGRAM HISTORY

23. ☐ Date of last pap smear: _____
24. ☐ Have you had abnormal pap smears? No ☐ Yes☐
25. ☐ Have had treatment for abnormal smears?
    If yes, what type(s) of treatment have you had: _____

26. Date of last mammogram: _____ _____
    Month Year
27. Have you had an abnormal mammogram? No ☐ Yes ☐

OTHER PAST GYNECOLOGICAL HISTORY

28. Check any that apply: ☐ None ☐ Venereal warts ☐ Herpes-genital ☐ Syphilis
☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea
☐ Vaginal infections ☐ Other _____

I PAST MEDICAL HISTORY Check any that apply: or ☐ None

☐ Arthritis
☐ Diabetes:
  ☐ Diet controlled
  ☐ Pill Controlled
  ☐ Insulin controlled
☐ High blood pressure
☐ Heart disease
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder
☐ Other:
_____

J CURRENT MEDICATIONS (Including dose (amount) per day)

Medication	Dose	Frequency

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K DO YOU CURRENTLY?: or ☐ None

29. Smoke No ☐ Yes ☐ _____packs/day
30. Use alcohol No ☐ Yes ☐ _____wine (glasses)/ beer (bottles)/ hard liquid (oz) per day
31. Use illicit drugs No ☐ Yes ☐ _____ type _____ amount
32. Exercise: Type:_____ How often _____

L DRUG ALLERGIES or ☐ None

33. If yes, please list:

_____
_____
_____
_____

M Family History or ☐ None

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other _____

☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer _____

If "yes" to any, please list affected relatives

_____ _____
_____ _____

N OTHER SYMPTOMS or ☐ None

Have you had recent?:

☐ weight loss ☐ hair growth ☐ breast discharge
☐ weight gain ☐ hair loss ☐ hot flushes/flashing
☐ change in energy ☐ change in urinary function ☐ other
☐ change in exercise tolerance _____

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