TORRANCE MEMORIAL
PHYSICIAN NETWORK

Today's Date: ____________________

# OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

**A NAME:** ____________________ **AGE:** ________ **DOB:** ______________

1. Marital Status: ☐ Single ☐ Married ☐ Long-term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: ____________________
3. Referring Physician: ____________________
4. Occupation: ____________________
5. Preferred phone number: ____________________

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

1. Age of first period: ______ years.
2. If your Menstrual periods are regular; periods start every: ______ days.
3. If your Menstrual periods are irregular; periods start every: ______ to ______ days. (e.g., 12 to 60)
4. Duration of bleeding: ______ days.
5. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
6. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
7. First day of last Menstrual period: ____________
8. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally
9. If yes, is it: ☐ before menses ☐ during menses ☐ both

**C PREGNANCY HISTORY (ALL PREGNANCIES)** ☐ **HAVE NEVER BEEN PREGNANT**
OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

| Year | Place of Delivery or Termination | Duration Pregnancy | Hours of Labor | Type of Delivery | Note Complications Mother and/or Infant<br>• Preeclampsia<br>• Gestational Diabetes<br>• Premature Labor<br>• Other / Specify | (Child) Sex | (Child) Birth Weight | (Child) Present Health |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**D BIRTH CONTROL HISTORY**
What birth control method(s) do you currently use? ____________________

TMPN/OBGYN
revised 06/20/16

## E SEXUAL HISTORY

1. Do you have a sexual partner? ☐ No ☐ Yes: ☐ Male ☐ Female
2. Are there concerns about your sexual activity which you may want to discuss with your doctor?
   ☐ Yes ☐ No

## F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: 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): List all surgeries and their year or ☐ None

| Surgery | Mo/Year | Complications |
|---|---|---|
| | | |
| | | |
| | | |

## H PAP SMEAR/MAMMOGRAM HISTORY

1. Date of last pap smear:____________: ☐ Normal ☐ Abnormal
2. Have you had abnormal pap smears? ☐ No ☐ Yes
3. Have you had treatment for abnormal smear? ☐ No ☐ Yes
4. If yes, what type(s) of treatment have you had?

| Treatment | Year | Treatment | Year |
|---|---|---|---|
| ☐ Cryotherapy | ________ | ☐ Cone Biopsy | ________ |
| ☐ Laser | ________ | ☐ Loop excision (LEEP) | ________ |

5. Date of last mammogram:____________
6. Have you had an abnormal mammogram? ☐ No ☐ Yes

## OTHER PAST GYNECOLOGICAL HISTORY: Check any that apply or ☐ None

☐ Venereal warts ☐ Herpes-genital ☐ Syphilis ☐ Pelvic Inflammatory Dis.
☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea ☐ Vaginal Infections
☐ HPV ☐ Other (specify) ________________________________

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

☐ Arthritis
☐ Diabetes:
  ☐ Diet controlled
  ☐ Pill controlled
  ☐ Insulin controlled
  ☐ Gestational
☐ High Blood Pressure
☐ Breast Cancer
☐ Kidney Disease

☐ Gallstones
☐ Liver Disease, includes hepatitis
☐ Epilepsy
☐ Eating Disorder
☐ Heart Disease
☐ Blood Clots Leg/Thigh
☐ Asthma
☐ Cancer (specify)
______________________________

☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Blood Transfusions
☐ Thyroid Disease
☐ Other (specify)
______________________________
______________________________
______________________________

## J CURRENT MEDICATIONS (include dose/amount per day)

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## K DO YOU CURRENTLY?

**Smoking:** ☐ Never ☐ Yes, Packs/Day:________ ☐ Cigarettes
☐ Former Years Smoked:________ ☐ VAP ☐ Hooka

**Alcohol:** ☐ Never ☐ Former ☐ Yes, Drinks/Week:________ Type:________________________

**Illicit Drugs:** ☐ Never ☐ Former ☐ Yes Type:________________________________________

**Caffeine Intake:** ☐ Yes ☐ No
☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate Daily Intake:____________

**Lifestyle:** Are you on a specific diet? ☐ Yes ☐ No If yes, which type of diet: ________________
Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise: ______________
Days/Week:__________________ Hours/Day: ___________________

## L DRUG ALLERGIES ☐ NO ☐ YES, LIST:

______________________________________________________________________________
______________________________________________________________________________

## M FAMILY HISTORY or ☐ None

| | Yes | Deceased *(Note age & cause)* | Affected Relatives *(Father, Mother, Brother, Sister, Son, Daughter)* |
|---|---|---|---|
| Diabetes | ☐ | ________________ | ________________________________________ |
| Ovarian Cancer | ☐ | ________________ | ________________________________________ |
| Heart Disease | ☐ | ________________ | ________________________________________ |
| Endometrial Cancer | ☐ | ________________ | ________________________________________ |
| Breast Cancer | ☐ | ________________ | ________________________________________ |
| Colon Cancer | ☐ | ________________ | ________________________________________ |
| Other/Specify | ☐ | ________________ | ________________________________________ |

## N OTHER SYMPTOMS or PROBLEMS: Check any that apply or ☐ None

☐ Weight Loss
☐ Weight Gain
☐ Breast Discharge
☐ High Cholesterol

☐ Hair Growth
☐ Hair Loss
☐ Hot Flushes/Flashing
☐ Physical Abuse/Domestic Violence

☐ Change in Energy
☐ Change in Exercise Tolerance
☐ Change in Urinary Function
☐ Other (specify)____________________

O **COMPLETE ONLY IF YOU ARE PREGNANT or PLANNING TO BE PREGNANT IN THE NEAR FUTURE**

**Have you or the baby's father or anyone in our families ever had the following:**

Down Syndrome? If yes, who?______________________________

Other Chromosomal abnormality? If yes, specify ______________________________

Neural tube defect (spina bifida, anencephaly)? If yes, who? ______________________________

Hemophilia or other coagulation abnormality? If yes, who? ______________________________

Muscular Dystrophy? If yes, who?______________________________

Cystic Fibrosis? If yes, who?______________________________

If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

Father Result ______________________________

Mother Result ______________________________

If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?

Father Result ______________________________

Mother Result ______________________________

If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalessemia?

Father Result ______________________________

Mother Result ______________________________

If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?

Father Result ______________________________

Mother Result ______________________________

______________________________________________________________________

PATIENT SIGNATURE DATE