WOMEN'S HEALTH CLINIC
GYN QUESTIONNAIRE

Patient's Name: _____ DOB: _____

Main reason for today's visit: _____

First day of your last menstrual period:_____ Menopause? Yes / No Year? _____

Allergies: _____ Hysterectomy? Yes / No Year? _____

# of pregnancies: _____ # of deliveries: _____ # of living children: _____

Birth Control Method: ___ None; ___ Pills; ___ Patch; ___ Ring; ___ Injection; ___ Diaphragm; ___ Condoms

___ Spermicide; ___ Natural FP; ___ Tubal Ligation; ___ Vasectomy; ___ IUD Type: _____

Do you smoke?: Yes / No How much: _____ Are you interested in quitting? Yes / No

Do you drink?: Yes / No How Much: _____ Do you feel safe in your current environment?: Yes / No

Do you have any pain?: Yes / No Where? _____ Pain Scale: (1=very mild 10=severe): _____

When was your last pap smear: _____ When was your last Mammogram: _____

Any history of abnormal PAPs? Yes / No When? _____ Colonoscopy? Yes / No When? _____

List all current medication (including over-the-counter): _____

_____

List all past surgeries: _____

_____

Do you or anyone in your family have/had:

SELF	FAMILY	
_____	_____	High Blood Pressure
_____	_____	Heart Disease
_____	_____	High Cholesterol
_____	_____	Thyroid Problems
_____	_____	Diabetes/Gestational Diabetes
_____	_____	Blood Clotting Issues
_____	_____	Stroke
_____	_____	Hepatitis
_____	_____	Seizures
_____	_____	Osteoporosis
_____	_____	Cancer: Type: _____

Have you ever experienced:

_____ DES Exposure

_____ Sexually Transmitted Disease

Type: _____

_____ Bladder or Bowel Problems

_____ Sexual Abuse

_____ Unexplained weight change

_____ Change in your health status

_____ Other: _____

I learn best by: _____Visual _____ Aural/Listening _____ Read/Write _____ Kinetics (Hands-on)

Barriers to Learning: _____

Primary Language: _____ English _____ Spanish _____ Other: _____