

CARE FOR YOU OB GYN, PLLC.
PATIENT HISTORY QUESTIONNAIRE

Name: _____ D.O.B _____ / _____ / _____ Age: _____ Today's Date: _____ / _____ / _____

Name of Primary Care Physician: _____ Who referred you? _____

Reason for visit: _____ DRUG ALLERGIES/REACTION: _____

Number of Pregnancies: _____ Number of Children Born: _____

Have you or anyone in your family (Mom, Dad, siblings, grandparents) had the following:
 (Use MGM for maternal grandmother, PGF for paternal grandfather, etc.)

What Surgeries have you had?
SURGERY DATE

	SELF	OTHER FAMILY MEMBERS
Alzheimer's		
Birth Defects		
Blood Clot History		
Breast Cancer		
Other Cancer		
Diabetes		
Epilepsy		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Osteoporosis		
Stroke		
Twins		

Have you ever had a DEXA Scan?

NO YES

Results: Normal Osteopenia

Osteoporosis

Have you ever had a Colonoscopy?

NO YES

When was your last one? _____

Normal Abnormal

Was told to follow up in _____ yrs.

Please Circle any of the following YOU have had:

- | | | | |
|---------------------|-------------------|-------------------------------|------------------------|
| Asthma | Hepatitis (A/B/C) | Mitral Valve Prolapse | -Human Papilloma Virus |
| Blood Transfusion | High Cholesterol | Sexually Transmitted Disease: | -Syphilis |
| Bowel Problems | Kidney Stones | -Chlamydia | Substance Abuse |
| Depression | Lung Disease | -Genital Warts | Thyroid Disease |
| Fibromyalgia | Lupus | -Gonorrhea | Ulcers |
| Gallbladder Disease | Migraines | -Herpes | |

How old were you when you had your first menstrual cycle? _____

Are your menstrual cycles regular? Y N How many days apart are they? _____ Duration? _____

Are they heavy? Y N Severe Cramping? Y N

When was the first day of you last menstrual cycle? _____

When was your last Pap smear? _____

Have you ever had an abnormal Pap smear? Y N When? _____ How was it treated? _____

When was your last mammogram? _____

Have you ever had intercourse? Y N

How many sexual partners have you had in the last 6months? _____

Are you sexually active with men? Y N women? Y N or both? Y N

What method of contraception do you or your partner use? _____

Has your partner had a vasectomy? Y N

Do you smoke cigarettes? Y N If so, how many per day? _____

How many servings do you consume each week of: Beer _____ Wine _____ Hard Liquor _____

How many servings of caffeine do you consume each day? _____

What vitamins/ herbal supplements do you take regularly? _____

Do you take Calcium Supplements? Y N If so how many mg? _____ mg How many times a day? Once Twice

Please list the name, dosage and dosing schedule of any medication you currently take:

Patient's Signature: _____ Date: _____

Provider's Signature : _____ Date: _____

