MADISON WOMEN'S CLINIC

GYN CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name:________________________________Date__________________________ Age_______________________

Main reason seeking medical attention: ☐Routine Physical ☐Problem

Describe Problem: ____

____

A. GYNECOLOGICAL HISTORY

1. Age at first period___________ Date of last menstrual period____________ Previous______________
2. When not on birth control pills, the interval between first day of one period to first day of next period ranges from ________ to ________ days. Duration of flow is _________ days.
3. Menstrual flow is usually ☐light ☐moderate ☐heavy ☐excess flow with clots
4. Do you ever have bleeding between periods or after intercourse? ☐yes ☐no
5. Do you have pain with periods? ☐yes ☐no At other times? ☐yes ☐no If yes, when?_________
6. When was your last Pap smear?________________ Was it normal? ☐yes ☐no
7. When was your last mammogram?_______________ Was it normal? ☐yes ☐no
8. What are you using for birth control? ☐Birth Control Pill_________________ ☐Condoms ☐IUD ☐Depo-Provera ☐Injections ☐Rhythm Method ☐Diaphragm ☐Sterilization ☐None ☐Other

		YES	NO	COMMENTS
9.	Are you satisfied with the present method of birth control?	☐	☐	________________
10.	Do you have any new sexual partners?	☐	☐	________________
11.	Do you ever have pain with intercourse?	☐	☐	________________
12.	Would you like testing for STD's?	☐	☐	________________
13.	Do you have any other sexual difficulties?	☐	☐	________________
14.	Do you have any unusual vaginal discharge, irritation, or dryness?	☐	☐	________________
15.	Do you ever leak urine when you cough or sneeze?	☐	☐	________________
16.	Do you frequently have a sudden urgent need to urinate?	☐	☐	________________
17.	Do you have problems with urinating frequently at night or bed wetting?	☐	☐	________________
18.	Do you have painful urination or difficulty in starting urination?	☐	☐	________________
19.	Do you ever have a protrusion or bulging sensation from you vagina?	☐	☐	________________
20.	Have you ever had a herpes virus infection?	☐	☐	________________
21.	Have you ever had gonorrhea, Chlamydia, Syphilis, or venereal warts?	☐	☐	________________
22.	Have you ever had an abnormal Pap smear?	☐	☐	________________
23.	Have you felt any lumps or changes in your breasts?	☐	☐	________________
24.	Have you had any nipple discharge?	☐	☐	________________
25.	Do you have breast implants?	☐	☐	________________
26.	Do you do monthly self-breast examinations?	☐	☐	________________

CURRENT MEDICATIONS: ____

____

DRUG ALLERGIES AND REACTIONS: ____

Label

B. OBSTETRICAL HISTORY

1. How many times have you been pregnant?________
2. Number of children living______ Number of miscarriage______ Number of abortions______
3. Were any of your babies born more than 3 weeks before their due date? ☐yes ☐no
4. When were your babies born, and how much did they weigh?____
5. Did you have any problems with your pregnancies, and if so, what were they?_______________________________

C. HOSPITALIZATIONS–List all hospitalizations including operations you have had with date, reason, and name of hospital:

	Date	Hospital	Reason
1.	____________	____________________	____________________________________
2.	____________	____________________	____________________________________
3.	____________	____________________	____________________________________
4.	____________	____________________	____________________________________

Have you ever had a blood transfusion? ☐yes ☐no

C. ILLNESSES

Have you or any blood relative ever had any of the following:

	YOU	FAMILY	(relationship- Maternal or Paternal)		YOU	FAMILY	(relationship- Maternal or Paternal)
Heart Problems	☐	☐	________________	Breast Cancer	☐	☐	________________
High Blood Pressure	☐	☐	________________	Ovarian Cancer	☐	☐	________________
Stroke	☐	☐	________________	Uterine Cancer	☐	☐	________________
High cholesterol	☐	☐	________________	Colon Cancer	☐	☐	________________
Diabetes	☐	☐	________________	Other Cancers	☐	☐	________________
Blood Clots	☐	☐	________________				
Bleeding disorder	☐	☐	________________	Depression	☐	☐	________________
Asthma or hayfever	☐	☐	________________	Epilepsy	☐	☐	________________
Liver or gall bladder problems	☐	☐	________________	Arthritis	☐	☐	________________
Colon polyps	☐	☐	________________	Downs Syndrome	☐	☐	________________
Kidney problems	☐	☐	________________	Birth defects	☐	☐	________________
Thyroid Problems	☐	☐	________________	Other ______________________________			

E. SYSTEMS REVIEW – Check any of the following that you have now or have had in the past six months

☐Headaches, dizziness	☐Shortness of breath	☐Diarrhea, constipation, changes in stool
☐Visual changes	☐Chronic cough or coughing up blood	☐Blood or black stools
☐Ringing in ears	☐Hot flashes or night sweats	☐Fatigue
☐Loss of consciousness or fainting	☐Varicose veins, easy bruising	☐Weight gain or loss
☐Numbness or tingling	☐Changes in skin or hair	☐Anxiety or depression
☐Chest pain	☐Abdominal pain, nausea, vomiting	☐Infertility

Comments____

When was your last Tetanus booster shot? _______________ Are you immune to Rubella (German Measles)? ☐ yes ☐ no

When did you last have your cholesterol level checked?_______ What was it? ____________________________________

Have you had a Gardasil Injection?_______ If yes, when?__________ Zostavax?__________ If yes, when?_________

F. SOCIAL HISTORY

Occupation:_____________________________ Employer:____________________ Marital status:______________________

Education – Grade last completed:_________________________ Religion_______________________________________

Do you smoke? ☐yes_____packs per day ☐no Do you drink alcohol? ☐never ☐occasionally ☐daily

Have you ever used any drugs? ☐yes ☐no If so, what?____

Do you have any history of physical, emotional, or sexual abuse? ☐yes ☐no

Do you exercise regularly? ☐yes ☐no What type of exercise?____________________ How long?____________

Do you wear seatbelts? ☐always ☐sometimes ☐never

Patient Signature:____