PAINT CREEK
O · B · G · Y · N

Patient History Questionnaire

Name: _____ DOB: _____

1. Do you have any **allergies** to any medications? Y/N
   If yes, which ones? _____

2. List all **medications** (including dosages) you take on a regular basis:

   _____ _____
   _____ _____
   _____ _____
   _____ _____

3. **GYNECOLOGICAL HISTORY**:
   At what age did your menstrual cycle begin? _____
   Are your periods regular? _____
   Any recent changes with your periods? _____
   How many days are there between your periods? _____
   How many days does your period last? _____
   Are your periods light, medium, or heavy? _____
   Do you spot or bleed between your periods? _____
   Do you spot or bleed after intercourse? _____
   Are you currently sexually active? _____
   Number of sexual partners (lifetime): _____
   What form of contraception do you currently use? (Please circle)
   Abstinence, Rhythm/Natural Family Planning, Condoms, Diaphragm, Birth Control Pills, IUD, Tubal Ligation, Vasectomy, Other
   When was your last pap smear? _____
   Have you ever had an abnormal pap test and what was the result?
   _____
   If yes, did you have a colposcopy or other cervical procedures?
   _____
   Have you had the Gardasil vaccine and did you complete the series?
   _____
   Have you ever been diagnosed with a sexually transmitted disease? (Please circle)
   Gonorrhea, Chlamydia, Genital warts or Human Papilloma Virus (HPV), Herpes, Syphilis, or Pelvic Inflammatory Disease (PID)
   When was your last mammogram (if applicable)? _____

4. **OBSTETRICAL HISTORY**: (Please specify ALL pregnancies including any miscarriages, ectopic pregnancies, still births and abortions)

Date of Delivery	*C-Section or Vaginal*	*Anesthesia*	*Complications*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When your mother was pregnant with you, did she take DES to prevent miscarriage? _____

5. Please list any **medical conditions** you have been diagnosed with and how you are being treated:

_____
_____
_____
_____

What is the name of your primary care physician? _____

6. **SURGICAL HISTORY**: Please list ALL surgeries and dates

Date	*Type of Surgery*	*Date*	*Type of Surgery*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. **FAMILY HISTORY**: Please indicate whether immediate relatives (parents, siblings, grandparents, aunts/uncles, cousins, or children) have or died from any of the following:

Cancer:	*Other Family Health History:*	
Breast _____	Hypertension _____	Mental Illness _____
Ovarian _____	Heart Attack _____	Obesity _____
Uterine _____	Stroke _____	Other _____
Cervical _____	Diabetes _____	
Colon _____	Osteoporosis _____	
Other _____		

8. **SOCIAL HISTORY**:

What is your marital status? _____
Do you drink alcohol? _____If yes, how much/often? _____
Do you smoke? _____If yes, how much per day? _____
Do you use any recreational drugs? _____
What is your occupation? _____