

OAKLAND-MACOMB OBSTETRICS AND GYNECOLOGY, P.C.

This questionnaire is confidential and will be considered part of your medical record.

The accurate completion of this form will be of value in evaluating your medical history. Thank you

Name _____ Today's Date _____

Address _____ Age _____ Birth date _____

Occupation _____

Telephone (H) _____ (W) _____ (C) _____

Email address _____ May we use email to inform you of results? **Yes / No**

What is the reason for your visit? _____

Do you have any drug allergies? Yes / No Latex allergy? **Yes / No**

Allergy _____ **Reaction** _____

What is your weight _____ height _____

Please check the conditions that you have now or have had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Abnormal Pap Smears |
| <input type="checkbox"/> Cervical /Ovarian/Uterine cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Venereal warts/HPV |
| <input type="checkbox"/> Fibrocystic breast | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Kidney stones/disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Liver/gallbladder disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gonorrhea/Chlamydia |
| <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Major accident |
| <input type="checkbox"/> Asthma/bronchitis | <input type="checkbox"/> Rubella/German measles | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Epilepsy/Seizures | | <input type="checkbox"/> Other psychological illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other illness _____ | |

Have you ever had surgery?

Surgery _____ Hospital _____ Date _____ Reason _____

Please list current medications:

Medication _____ **Dosage** _____ **For how long** _____

What vitamins or herbal supplements do you use? _____

Immunization History: Up to date Unsure Need Immunizations

Family History: Please check the diseases below that affect your family members, and list their relation to you:

Breast Cancer _____ Ovarian Cancer _____ Colon Cancer _____

Uterine Cancer _____ Uterine fibroids _____ Other cancer (type) _____

Diabetes _____ Heart disease _____ Osteoporosis _____

High cholesterol _____ Thyroid disease _____ Hypertension _____

Birth defects _____ Mental retardation _____ Endometriosis _____

Blood clots/DVT _____ Genetic disorders _____ Other _____

What is your nationality? _____

Marital status _____ Years in current relationship _____

Partner's name _____ Partner's occupation _____

Partner's history: Hepatitis _____ Herpes _____ Any sexually transmitted diseases _____

OAKLAND MACOMB OSTETRICS AND GYNOCLOGY, P.C.

Please check the method(s) of birth control that you are currently using:

Birth Control pill/patch Condoms NuvaRing Diaphragm Vasectomy
 Tubal Ligation IUD Spermicide Withdrawl Rhythm/NFP Abstinence None
 Are you still having periods? **Yes/No** Date of last period _____
 If no when did they stop? _____ If yes are they: Regular / Irregular
 Have you had a hysterectomy? **Yes/No** If yes Reason for _____
 Number of days of flow _____ Light / Moderate / Heavy
 How old were you when your periods began? _____ Do you still have your ovaries? **Yes/No**
 How many days from the **start of one cycle** to the **start of another**? _____
 Last Period ____/____/____ Last Mammogram ____/____/____ Last Pap ____/____/____

Pregnancy History: Number of pregnancies? _____ Miscarriages? _____ Abortions? _____
 Number of living children? _____ What years were you children born? _____
 How many sexual partners have you had in the past year? _____
 Are you satisfied with your sex life? **Yes/No** If not why? _____
 Do you experience dryness or pain with sexual activity? **Yes/No**
 Do you use lubricants? **Yes/No** Any loss in sexual interest? **Yes/No**
 Do you orgasm as easily and frequently as you desire? **Yes/No**
 Are you trying to get pregnant? **Yes/No** If so for how long? _____
 Have you ever taken "fertility" drugs? **Yes/No** Which ones? _____

History: Have you ever been emotionally, sexually or physically abused? **Yes/No**
 If yes, please explain _____
 Do you smoke? **Yes/No** How many packs per day? _____ For how many years? _____
 Do you drink alcohol? **Yes/No** How many drinks per week? _____ For how many years? _____
 Do you use recreational drugs? **Yes/No** If yes, which drugs? _____
 Have you ever been addicted to drugs or alcohol? **Yes/No**
 Do you drink caffeinated beverages? **Yes/No** How many per day? _____
 What kind of exercise do you do? _____ How often? _____

Please check any of the following symptoms that may apply to you:

hot flashes night sweats fatigue migraines not sleeping
 irritability mood swings suicidal thoughts depression waking early
 recent wt.gain recent wt. loss visual disturbances anxiety other _____
 loss of urine with cough or sneezing pain with urination frequent urination

If you are currently pregnant, please complete the following information about your previous pregnancies (including any miscarriages or abortions).

Year	Hospital	#Weeks at delivery	#Hours in Labor	Sex	Weight	Type of delivery	Complications	Baby's Name

I understand that this is a confidential questionnaire and I have answered the above to the best of my knowledge.

Please print name _____
 Signature _____ Date: _____ (7/07gb)