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:

__Breast cancer	__Heart disease	__Abnormal Pap Smears
__Cervical /Ovarian/Uterine cancer	__Heart murmur	__Vaginal infections
__Abnormal mammogram	__Mitral valve prolapse	__Pelvic Inflammatory Disease
__Breast biopsy	__Hypertension	__Venereal warts/HPV
__Fibrocystic breast	__High cholesterol	__HIV/AIDS
__Ovarian cysts	__Kidney stones/disease	__Hepatitis
__Uterine fibroids	__Liver/gallbladder disease	__Herpes
__Bleeding problems	__Osteoporosis	__Gonorrhea/Chlamydia
__Blood clots/DVT	__Thyroid disease	__Syphilis
__Endometriosis	__Ulcer disease	__Trichomonas
__Arthritis	__Chicken Pox	__Major accident
__Asthma/bronchitis	__Rubella/German measles	__Depression/Anxiety
__Epilepsy/Seizures		__Other psychological illness

__Diabetes __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_____.

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)