CHRISTUS ST. VINCENT
Women's Care Specialists

GYN/OB Patient Questionnaire

Patient Name: ______________________________ **Date of Birth**: ___________________ **Todays Date**: _________________
Occupation: ____
Phone Number:
Home ___________________________ Cell ___________________________ Work ___________________________
Emergency Contact:
Name: _________________________________ Relation: ________________________ Phone Number: _________________

Past Medical History: Please check any conditions that pertain to you or a blood relative

	Self	Fam	Explain		Self	Fam	Explain
Headaches				Blood Transfusions			
Heart/Vascular Disease				Anemia/Blood Disorder			
Rheumatic				Stroke			
High Blood Pressure				DVT/Pulmonary Embolism			
High Cholesterol				Skin Disease			
Respiratory Disease				Diabetes			
Pulmonary (Lung) / Asthma				Thyroid Diseases			
Breast Cancer				Cancer (Type)			
Jaundice/ Hepatitis				Uterine abnormalities			
Reflux/Ulcer				Epilepsy/Neurological Disease			
Bowel Disease/Colon Cancer				Arthritis -Joint Pain			
Kidney Disease				Osteoporosis/ Joint Problems			
Urinary Incontinence				Anxiety/Depression			
Urinary Infections				Postpartum depression			
ART Treatment				D (Rh) Sensitized			
STD's			Partner? Y / N	Sleep Problems			
Varicosities/Phlebitis				Anesthetic Complications			
Infertility				Seasonal Allergies			

Drug Allergies/Reactions?:

____
____
____

Vaccines: Chicken Pox □ | Childhood Vaccines □ | HPV □ | Hepatitis A □ | Hepatitis B □ | Last Tetanus: __________

Past Surgical History or Hospitalizations (Provide year of procedure and what type):

____
____
____

List of Current Medications:

____
____
____

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Menstrual History:

Age at first period: ____ | 1st day of last period: _______ | Cycle length: _______ | Duration of bleeding: _____

Cramps: Y / N | **If yes:** Mild ☐ Moderate ☐ Severe ☐ Always present ☐ |Bleeding: Light ☐ Moderate ☐ Heavy ☐

Hot Flashes: Y / N **| If yes**, treatment? ___________________________________

PAP Last test: ________ Ever had an abnormal result**:** Y / N **| Last Mammogram:** ______ Ever had an abnormal result**:** Y / N

Current Method of Contraceptive: ____

Are you considering getting pregnant in the future: ____

Social History:

Smoking, Cig per day: ________ Years: ________ | Alcohol, Oz. /Week: ___________ | Caffeine, Cups/Day: __________

Illicit Drugs, what kind and how often (if any):

____

Are you currently sexually active: Y /N | with Men? Y / N | with Women? Y / N

How many sexual partners have you had in your lifetime: ____

Do you feel safe at home: ____

Obstetrical History:

of Pregnancies:_____ | Premature Babies: _____ | Miscarriages: _____ | Abortions: _____ | Living Children: _____

	Child DOB	Weeks Preg.	WT	SEX	Type of Delivery	Remarks		Child DOB	Weeks Preg.	WT	SEX	Type of Delivery	Remarks
1							4						
2							5						
3							6						

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Genetic Screening/Teratology Counseling

(For pregnant patients only)

Include patient, baby's father, or anyone in either family with:

		Yes	No			Yes	No
1	Patients age 35 yrs., or older, at estimated date of delivery			12	Cystic Fibrosis		
2	Thalassemia (Italian, Greek, Mediterranean, or Asian Background) MCV<80			13	Huntington's Chorea		
3	Neural Tube Defect (Meningomyelocele, spina bifida, or anencephaly)			14	Mental Retardation/Autism		
4	Congenital Heart Defect				If yes to 14, was person diagnosed, Fragile X?		
5	Down Syndrome			15	other inherited genetic or chromosomal disorder		
6	Canacan disease (Ashkenazi Jewish)			16	Maternal Metabolic Disorder (Type I Diabetes, PKU)		
7	Tay-Sachs (Ashkenazi Jewish)			17	Patient, or baby's father, had a child with birth defects not listed above		
8	Familial Dysautonomia (Ashkenazi Jewish)			18	Recurrent pregnancy loss, or still birth		
9	Sickle Cell Disease or Trait (African)			19	Medications (supplements, vitamins, over the counter, or prescribed) illicit/recreational drug use since last menstrual period		
10	Hemophilia or Other Blood Disorder				If yes to 19, what was it, and how much?		
11	Muscular Dystrophy						

Infection History

		Yes	No			Yes	No
1	Live with someone with TB or exposed to TB			4	Hepatitis B, C		
2	Patients or partner has history of genital herpes			5	History of STD, Gonorrhea, Chlamydia, HPV, HIV, Syphilis		
3	Rash or viral illness since last menstrual period						