GREATER BALTIMORE MEDICAL CENTER
DIVISION OF GYNECOLOGY/UROGYNECOLOGY

HISTORY/QUESTIONNAIRE

Please complete this form for your first visit

Name_____ Date_____

Birthdate_____ Age_____

Primary Care Physician_____ Referring Physician_____

Please describe the reason for your visit today

_____

_____

OBSTETRICAL & GYNECOLOGICAL HISTORY

Number of pregnancies_____
Number of children born alive_____
Number of vaginal deliveries_____
Of these vaginal deliveries, how many involved forceps of vacuum_____
What was the weight of your largest child delivered vaginally (in pounds)_____
Have you had at least one episiotomy or vaginal tear? Yes/No/Unknown
Number of cesarean deliveries _____
Number of ectopic (tubal) pregnancies _____
Number of miscarriages _____
Number of abortions _____

How old were you when your period started?_____
When was your most recent period?_____
Are you still having your period (menstruating)
If you are still having your period:
How often do you have your period? (Please pick one)

- o Regularly (about once a month)
- o Too frequently
- o Infrequently

Is your flow? (Please pick one)

- o Normal
- o Light
- o Heavy

Do you have severe menstrual cramps? Yes/No

Have you stopped having periods?
If yes, at what age? _____
Are you currently taking hormone replacement therapy? (Please pick one)

- o None
- o Continuous (same pill/pills every day)
- o Cyclic

Did you ever take hormones in the past? If so, when did you stop?_____

Date of last Pap Smear _____ Normal? Yes_____ No_____

Date of last Mammogram_____ Normal? Yes_____ No_____

Have you ever been diagnosed with a sexually transmitted disease? Yes _____ No _____
If so, which one (s)_____

Have you had any treatment to your cervix?

Cautery/LEEP_____ Other_____

Cryosurgery_____ If yes, when?_____

Are you sexually active at this time?
Yes_____ No_____

Do you experience bleeding after intercourse?_____ If yes, duration_____

Is your sex life satisfactory for you? Yes_____ No_____

What type of contraception are you using? _____

Have you ever been a victim of sexual, domestic, or physical abuse? _____

PAST MEDICAL HISTORY

PLEASE LIST YOUR MEDICAL PROBLEMS:

_____

_____

_____

_____

PLEASE ANSWER YES OR NO

AS A CHILD DID YOU HAVE:

_____ Rheumatic Fever
_____ Scarlet Fever
_____ Rubella (Measles)
_____ Other

AS AN ADULT HAVE YOU HAD:

_____ Bladder Infections
_____ Chronic Fatigue Syndrome
_____ Diabetes
_____ Kidney Disease
_____ Kidney Infections
_____ Liver Disease
_____ Pneumonia
_____ Stroke
_____ Glaucoma
_____ Asthma
_____ Heart Disease
_____ Epstein Barr Virus
_____ High Blood Pressure
_____ Jaundice
_____ Mononucleosis
_____ Serious Injuries of Accident
_____ Tuberculosis
_____ Sexually Transmitted Diseases

PAST SURGICAL HISTORY
Please list ALL previous surgeries:

_____

_____

_____

_____

Have you had any of the following **gynecologic** surgeries?

Dilation and curettage Yes/No
Hysteroscopy Yes/No
Hysterectomy (please pick one)

- None
- Total abdominal hysterectomy
- Total vaginal hysterectomy
- Laparoscopic hysterectomy

Surgery on an ovary Yes/No
Surgery to remove one or both ovaries Yes/No
Removal of tube Yes/No
Surgery for urinary incontinence Yes/No
Surgery for Prolapse ("bladder tuck, etc…) Yes/No

MEDICATIONS/ALLERGIES

Please list all medicines that you are currently taking including contraceptives and vitamins; Include dose and frequency.

_____

_____

_____

_____

Do you have any **ALLERGIES**? If so, please list:

_____

FAMILY HISTORY

Has anyone in your family had any of these diseases? If so, please give relationship.

Breast Cancer _____
Colon Cancer _____
Gynecological Cancer _____
Other Cancer _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Osteoporosis _____
List Other Diseases _____

SOCIAL HISTORY

Current marital status: Married_____ Single_____ Divorced_____ Widowed_____ Separated_____

Occupation_____

HEALTH HAPITS

How many hours do you sleep per day? _____

Do you eat regular meals including breakfast? Yes_____ No _____

Do you eat whole grain bread and cereal, fresh fruit and vegetables daily? Yes_____ No_____

Do you consider yourself healthy? _____ Do you exercise regularly? _____

What type of exercise do you do? _____

What do you do to relax? _____

How would you describe your caffeine intake? _____

Do you smoke: Yes_____ No_____ Previous_____ How many packs a day?_____

Do you wear your seatbelt? Yes_____ No_____

REVIEW OF SYMPTOMS

Please check of you have had any of the following recently:

General

_____ Weakness
_____Fatigue
_____ /Recent weight loss
_____ Heat of cold intolerance
_____ Night sweats

Genitourinary

_____ Urinary frequency
_____ Urinary incontinence

Chest

_____ Difficulty breathing
_____ Chronic Cough

Neurologic

_____ Headaches
_____ Dizziness
_____ Fainting Spells
_____ Seizures
_____ Tremors
_____ Difficulty Walking

Skin

_____ Change in mole
_____ Skin rashes
_____ Itching
_____ Hair loss

Cardiovascular

_____ Chest pain
_____ Shortness of breath
_____ Heart murmur
_____ Leg pain with exercise
_____ Leg swelling
_____ Varicose Veins
_____ Blood clots

Head and Neck

_____ Hearing loss
_____ Sinus infection
_____ Hoarseness
_____ Nosebleeds
_____ Enlarged thyroid
_____ Glaucoma

Hematologic

_____ Early bruising
_____ Prolonged bleeding
_____ Lumps in neck or groin
_____ Bleeding gums

Gastrointestinal

_____ Appetite change
_____ Nausea
_____ Vomiting
_____ Indigestion or heartburn
_____ Difficulty swallowing
_____ Constipation
_____ Diarrhea
_____ Black stool
_____ Hemorrhoids

Breast

_____ Breast pain
_____ Breast lumps
_____ Nipple discharge
_____ Breast size change

Musculoskeletal

_____ Back pain
_____ Joint pain
_____ Joint swelling

Psychiatric

_____ Psychiatric treatment
_____ Nervousness
_____ Depression
_____ Thoughts of suicide