New GYN Questionnaire **Patient Name:**

Gynecological and Sexual History

When was the first day of your last period? _____ How many days do your periods last?_____

Are your periods regular? ☐ Yes ☐ No How often do you get periods? Every _____days

How many pads/tampons do you use on your heaviest day?_____

At what age did your periods begin? _____

Do you have painful periods? ☐ Yes ☐ No Do you bleed in between your periods? ☐ Yes ☐ No

Are you using birth control? ☐ Yes, Type: _____ ☐ No

Have you ever been sexually active? ☐ Yes ☐ No

Have you had any new sexual partners in the past 12 months? ☐ Yes, _____ # of partners ☐ No

Do you have sex with: ☐ Men ☐ Women ☐ Both

Do you bleed after intercourse? ☐ Yes ☐ No

Do you have any pain or discomfort with sexual intercourse? ☐ Yes ☐ No

Did you want to be tested for sexually transmitted diseases today? ☐ Yes ☐ No

Do you feel safe in your relationship? ☐ Yes ☐ No

Have you ever experienced any sexual abuse or trauma? ☐ Yes ☐ No

Please list the date of your most recent pap smear: _____

Please list the date of your most recent mammogram: _____

Please list the date of your most recent colonoscopy: _____

Please list the date of your most recent Bone Density (DEXA)_____

Obstetrical History

# of Pregnancies	# Vaginal Birth	# C-sections	# Abortions	# Miscarriages	# Living Children

List Any Complications in Pregnancy (high BP, diabetes, etc):_____

Menopausal History

Have you stopped menstruating? ☐ Yes ☐ No What age did you stop menstruating? _____

Have you had bleeding since you stopped menstruating? ☐ Yes ☐ No

Are you experiencing any menopausal symptoms you would like to discuss at your appointment? ☐ Yes ☐ No

List any **Allergies** you have:

Have you ever used any of the following substances?

Tobacco	☐ No	☐ Yes, previously	☐ Yes, currently #packs/day _____
Vape	☐ No	☐ Yes, previously	☐ Yes, currently #times/day _____
Alcohol	☐ No	☐ Yes, previously	☐ Yes, currently #drinks/day _____
Recreational Drugs	☐ No	☐ Yes, previously	☐ Yes, currently _____

Surgical History

Please indicate any surgeries you have had

Type of Surgery	Your Age When occurred

Medical History

Have you ever been diagnosed with any of the following conditions? Check all that apply:

☐ High Blood Pressure	☐ Chlamydia	☐ Thyroid Disorder	☐ Infertility
☐ Abnormal Pap Smear	☐ Gonorrhea	☐ Seizures	☐ Hepatitis
☐ Depression	☐ Trichomoniasis	☐ Osteoporosis	☐ Fibroids
☐ Anxiety	☐ Syphilis	☐ Blood Disorder	☐ Blood Transfusion
☐ Diabetes	☐ Genital Herpes	☐ Migraines	☐ Endometriosis
☐ Asthma	☐ Genital Warts	☐ Osteoporosis	☐ PCOS
☐ Blood Clot	☐ HIV	☐ Urinary Issues	☐ Anemia

☐ Cancer _____ ☐ Other: _____

Family History

Please mark all that apply and the **age** that your family member was diagnosed.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Diabetes							
High Blood Pressure							
Breast Cancer							
Ovarian Cancer							
Cervical Cancer							
Uterine Cancer							
Colon Cancer							
Blood clots							

Please list any other medical problems in your family that you would like the doctor to know about and the family member that has it:

_____

_____

_____

Please mark if you have any of the following:

Fevers	
Chills	
Loss of appetite	
Weight gain	
Weight loss	
Cough	
Wheezing	
Coughing up blood	
Chest pain	
Palpitations	
Rapid heart rate	
Losing consciousness	
Difficulty swallowing	
Diarrhea	
Constipation	
Unable to hold bowel movement	
Rash	
Itching	
Easy bruising	
Joint pains	
Muscle weakness	
Headaches	
Tingling in extremities	
Weakness or numbness in extremities	
Suicidal thoughts	
Homicidal thoughts	
Leaking urine with cough, sneeze, or laughing	
Unable to hold urine	
Burning with urination	
Increased thirst	
Hives	
Swelling	
Nausea	