**Gynecology Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This is a brief questionnaire to help your doctor understand you and the reason you were referred. Please answer as many of the questions to the best of your ability. The more detailed the information you provide the better we are able to help you!

Age: \_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_

Do you Smoke? Yes No

Alcohol Consumption Never Occasional Often

Why were you sent to see us?

Please describe your goal for your visit today. What is most important to YOU?

Gynecology questions:

When was you last menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age menstrual cycle began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your menstrual cycles like?

How many days do they last? \_\_\_\_\_\_\_

How often do you get them? \_\_\_\_\_\_\_\_

Is the flow (circle one): Heavy Medium Light

Do you have flooding or leaking during your cycle? Yes No

Do you have bleeding in between your cycles? Yes No

Do you have pain during your cycle? Describe it.

Do you have pain before or in between your cycles? Describe it.

Do you have pain during intercourse? Yes No

Do you have problems with leaking urine? Yes No

When was your last pap smear? \_\_\_\_\_\_\_\_\_

Have you had any abnormal pap smears? Yes No

Have you had any sexually transmitted infections? Describe.

Medical History:

Do you have any medical problems? If so, please list and describe:

**1.**

**2.**

**4.**

**5.**

**3. 6.**

Surgical History:

Have you ever had surgery? If so, please list and describe including minor procedures:

1.

2.

3.

4.

Obstetrical History:

Please describe your pregnancies and the way you delivered:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Year** | **Term/Miscarriage/Terminated** | **Vaginal/C Section** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

Medications: Please list

1.

2.

3.

4.

5.

Allergies: Please list and describe all of your medication allergies:

Please hand this questionnaire back to the front desk staff once you have finished it.

Thank you!