

# WOMEN PARTNERS IN HEALTH: Annual Gynecological Questionnaire

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.

1) Date \_\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

2) Changes in Marital Status since your last visit? \_\_\_\_\_

3) REASON FOR VISIT (please explain your symptoms and how long they have been occurring) \_\_\_\_\_

4) Please list current MEDICATIONS: \_\_\_\_\_

5) Preferred Pharmacy: Name: \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

6) Please list any significant ALLERGIES (i.e. LATEX, eggs, shellfish, etc.) \_\_\_\_\_

7) When was the FIRST day of your LAST MENSTRUAL PERIOD? (If applicable) \_\_\_\_\_

How many days do you have bleeding? (i.e. 4 days) \_\_\_\_\_ How OFTEN do your periods occur? (i.e. every 28 days) \_\_\_\_\_

8) What is your CURRENT BIRTH CONTROL METHOD? (Please choose one):

Nothing. . . . withdrawal. . . . condoms. . . . pills/ring/patch. . . . IUD. . . . tubal. . . . vasectomy. . . . menopause. . . . hysterectomy. . . . OTHER \_\_\_\_\_

If applicable, please list brand name of birth control pills/ring/patch/IUD: \_\_\_\_\_

If you have any concerns about this birth control method, please explain: \_\_\_\_\_

9) The American College of Obstetrics and Gynecology (ACOG) recommends:

- HIV screening for all women ages 19-64
- HIV screening for sexually active teenagers under the age of 19
- HIV screening for women older than 64 who have had multiple partners in recent years
- Annual Chlamydia screening of all sexually active women age 25 and younger
- HPV (human papilloma virus) screening, in addition to an annual pap smear, for women over the age of 30

I would like to be screened for the following sexually transmitted diseases today: (please circle) \*\*Note: We cannot guarantee insurance coverage for any tests\*\*

HPV    Chlamydia    Gonorrhea    Genital herpes    HIV    Syphilis    Hepatitis B    **No testing today**

10) Please list any CHANGES to your Medical/Surgical/Family history since you were last seen in our offices: \_\_\_\_\_

11) Please circle any of the symptoms below that you are having TODAY:

<b>Constitutional:</b>	<b>Circle One:</b>	<b>Genitourinary (continued)</b>	<b>Circle One:</b>
Frequent Fatigue	Current Past N/A	Frequent Urine leakage	Current Past N/A
Excess weight gain	Current Past N/A	Pain with intercourse	Current Past N/A
Excess weight loss	Current Past N/A	Genital sores	Current Past N/A
<b>Eyes, Ears, Nose, Mouth:</b>	<b>Circle One:</b>	Irregular periods	Current Past N/A
Frequent or severe headaches	Current Past N/A	Painful periods	Current Past N/A
Frequent lightheadedness	Current Past N/A	Heavy periods	Current Past N/A
<b>Breasts:</b>	<b>Circle One:</b>	No periods	Current Past N/A
Lumps	Current Past N/A	Possible pregnancy?	Current Past N/A
Tenderness/ Pain	Current Past N/A	Abnormal vaginal discharge	Current Past N/A
Swelling	Current Past N/A	Significant PMS	Current Past N/A
Nipple discharge	Current Past N/A	<b>Integument (skin):</b>	<b>Circle One:</b>
<b>Cardiovascular:</b>	<b>Circle One:</b>	New skin lesions	Current Past N/A
Chest pain	Current Past N/A	Changes to skin lesions or moles	Current Past N/A
Dizziness/Fainting	Current Past N/A	<b>Musculoskeletal:</b>	<b>Circle One:</b>
Swollen/Painful varicose veins	Current Past N/A	Joint pain	Current Past N/A
Calf pain	Current Past N/A	Joint swelling	Current Past N/A
<b>Respiratory:</b>	<b>Circle One:</b>	Recent back pain	Current Past N/A
Frequent shortness of breath	Current Past N/A	<b>Endocrine:</b>	<b>Circle One:</b>
Frequent Hoarseness	Current Past N/A	Excess bodily hair growth	Current Past N/A
<b>Gastrointestinal:</b>	<b>Circle One:</b>	Excess hair loss	Current Past N/A
Nausea/ Vomiting	Current Past N/A	Cold intolerance	Current Past N/A
Frequent Diarrhea	Current Past N/A	Heat intolerance	Current Past N/A
Frequent Constipation	Current Past N/A	Acne	Current Past N/A
Frequent Heartburn/ reflux	Current Past N/A	Thyroid abnormalities/ treatment?	Current Past N/A
Abdominal Pain	Current Past N/A	<b>Psychiatric:</b>	<b>Circle One:</b>
Blood in stool	Current Past N/A	Frequent Anxiety	Current Past N/A
Hemorrhoids	Current Past N/A	Frequent Depression	Current Past N/A
<b>Genitourinary:</b>	<b>Circle One:</b>	Suicidal thoughts	Current Past N/A
Urgency/ frequency	Current Past N/A	Past/Current psychiatric treatment	Current Past N/A
Pain with urination	Current Past N/A	<b>Hematologic/Lymphatic:</b>	<b>Circle One:</b>
Blood in urine	Current Past N/A	Easy bleeding	Current Past N/A
		Easy bruising	Current Past N/A

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

FOR STAFF ONLY BELOW THIS POINT:

\*\* DO NOT SCAN THIS SIDE \*\*

\*\* DO NOT SCAN THIS SIDE\*\*

Account # \_\_\_\_\_

Visit Care Provider:

Weight \_\_\_\_\_ Height \_\_\_\_\_ BP \_\_\_\_\_ Temp \_\_\_\_\_ UPT: Positive Negative

Urine Dip Results: Glucose \_\_\_\_\_ Bili \_\_\_\_\_ Ketones \_\_\_\_\_ Sp.Gravity \_\_\_\_\_ Blood \_\_\_\_\_ pH \_\_\_\_\_ Protein \_\_\_\_\_  
Urobili \_\_\_\_\_ Nitrite \_\_\_\_\_ Leuk \_\_\_\_\_

Pt desires: STD Testing.....Lipids.....Other \_\_\_\_\_

LABS ORDERED: \_\_\_\_\_

DIAGNOSIS CODES: \_\_\_\_\_

PROCEDURE CODES: \_\_\_\_\_