



## OBSTETRICS AND GYNECOLOGY

### Returning Patient Questionnaire

All information will be reviewed by your practitioner and kept confidential. If you don't understand a question, leave it blank and your healthcare team will assist you.

Name:

Date of Birth:

Age:

Today's Date:

Reason for today's visit:

Any hospitalizations since your last visit?

Any new medical conditions or surgeries?

Any new medications or allergies?

Any changes in alcohol or drug use?

### Prevention

Do You

- Smoke                       Get daily exercise                       Always use seatbelts  
 Eat a healthy diet                       Take a vitamin/calcium supplement

### Health Maintenance –Have you had the following in the past year?

- Dental visit \_\_\_\_\_                       Vision testing \_\_\_\_\_                       Mammogram \_\_\_\_\_  
 Bone density \_\_\_\_\_                       Colonoscopy \_\_\_\_\_                       Cholesterol \_\_\_\_\_  
 Pap smear \_\_\_\_\_

### Menstrual/sexual History

Last menstrual period began \_\_\_\_\_

My periods are  Regular     Irregular     Heavy     Normal     Painful

Manageable/tolerable     Unmanageable, I want to talk about options for treatment

Other problems \_\_\_\_\_

Method of contraception:

- None     Tubal ligation                       Partner had vasectomy                       Hormones (pill, patch, or ring)  
 Condoms     IUD                       Other \_\_\_\_\_

I have a new sexual partner

I am in a heterosexual relationship with my husband/significant other

I am in a same sex relationship

I am not currently sexually active

I have never been sexually active

**OVER**

**Post-menopausal Women**

- I have gone through menopause, with no bleeding in the past year
- I have experienced some vaginal bleeding or spotting in the last year
- I am on Hormone Therapy. (list type) \_\_\_\_\_
- I have taken Hormones in the past, and quit in \_\_\_\_\_.
- I am having difficulty with hot flashes or night sweats, and want to talk about treatment

**Review Of Systems**

Have you been experiencing any of the following problems?

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches                        | <input type="checkbox"/> Nausea / Vomiting                              |
| <input type="checkbox"/> Visual changes                   | <input type="checkbox"/> Constipation                                   |
| <input type="checkbox"/> Chest Pain                       | <input type="checkbox"/> Diarrhea                                       |
| <input type="checkbox"/> Cough / Wheeze                   | <input type="checkbox"/> Blood in stools                                |
| <input type="checkbox"/> Difficulty breathing             | <input type="checkbox"/> Frequency / Urgency of urination               |
| <input type="checkbox"/> Weight changes                   | <input type="checkbox"/> Leaking of urine                               |
| <input type="checkbox"/> Fevers                           | <input type="checkbox"/> Vulvovaginal pain, itching, rash, or discharge |
| <input type="checkbox"/> Felt lump in breast              | <input type="checkbox"/> Skin problems                                  |
| <input type="checkbox"/> Insomnia                         | <input type="checkbox"/> Depression                                     |
| <input type="checkbox"/> Abdominal pain                   | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Pelvic pain                      | <input type="checkbox"/> NONE   |
| <input type="checkbox"/> Fatigue                          |   |
| <input type="checkbox"/> Muscle or joint pain or weakness |   |
| <input type="checkbox"/> Increased thirst                 |   |
| <input type="checkbox"/> Shakiness/tremors                |   |