

# WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

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

## Patient Health History Questionnaire

Reason for your visit: \_\_\_\_\_

**PAST MEDICAL HISTORY:** (Do you have or have you ever had):  None

- |   |   |  |       |
|---|---|--|-------|
| <input type="checkbox"/> Alzheimer's Disease      | <input type="checkbox"/> Depression               | <input type="checkbox"/> Lung Cancer               | _____ |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Diabetes Mellitus        | <input type="checkbox"/> Migraine Headache         | _____ |
| <input type="checkbox"/> Anxiety Disorder         | <input type="checkbox"/> DVT (Venous embolism)    | <input type="checkbox"/> Mitral valve prolapse     | _____ |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Myocardial Infarction     | _____ |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Esophageal Reflux        | <input type="checkbox"/> Osteoporosis              | _____ |
| <input type="checkbox"/> Breast Cancer            | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Ovarian Cancer            | _____ |
| <input type="checkbox"/> Cardiac Arrhythmia       | <input type="checkbox"/> Hepatitis (A, B, or C)   | <input type="checkbox"/> Skin Cancer               | _____ |
| <input type="checkbox"/> Cervical Cancer          | <input type="checkbox"/> Hernia                   | <input type="checkbox"/> Stomach Cancer            | _____ |
| <input type="checkbox"/> Cholesterol, elevated    | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Stress Incontinence       | _____ |
| <input type="checkbox"/> Colon Cancer             | <input type="checkbox"/> Hyperthyroidism          | <input type="checkbox"/> Stroke (CVA)              | _____ |
| <input type="checkbox"/> Congestive Heart Disease | <input type="checkbox"/> Hypothyroidism           | <input type="checkbox"/> Transient ischemic attack | _____ |
| <input type="checkbox"/> COPD (Lung Disease)      | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Ulcer                     | _____ |
| <input type="checkbox"/> Coronary Heart Disease   | <input type="checkbox"/> Kidney stone             | <input type="checkbox"/> Uterine Cancer            | _____ |

Comments: \_\_\_\_\_

**PAST GYNECOLOGIC HISTORY:** (Do you have or have you ever had):  None

- |  |  |  |       |
|--|--|--|-------|
| <input type="checkbox"/> Abnormal PAP Smear          | <input type="checkbox"/> Dysmenorrhea              | <input type="checkbox"/> Menorrhagia (heavy menses)  | _____ |
| <input type="checkbox"/> Amenorrhea (no menses)      | <input type="checkbox"/> Dyspareunia (painful sex) | <input type="checkbox"/> Ovarian cyst                | _____ |
| <input type="checkbox"/> Anovulation                 | <input type="checkbox"/> Ectopic                   | <input type="checkbox"/> Pelvic adhesions            | _____ |
| <input type="checkbox"/> Bartholin's gland cyst      | <input type="checkbox"/> Endometriosis             | <input type="checkbox"/> Pelvic inflammatory disease | _____ |
| <input type="checkbox"/> Cervical Cancer             | <input type="checkbox"/> Fibroid uterus            | <input type="checkbox"/> PMS                         | _____ |
| <input type="checkbox"/> Candidiasis (chronic yeast) | <input type="checkbox"/> Gonorrhea                 | <input type="checkbox"/> Polycystic ovaries (PCOS)   | _____ |
| <input type="checkbox"/> Chlamydia                   | <input type="checkbox"/> Herpes Simplex (HSV)      | <input type="checkbox"/> Recurrent vaginitis         | _____ |
| <input type="checkbox"/> Condyloma Acuminatum        | <input type="checkbox"/> Hirsutism                 | <input type="checkbox"/> Syphilis                    | _____ |
| <input type="checkbox"/> Cystocele (dropped bladder) | <input type="checkbox"/> Human Papilloma Virus     | <input type="checkbox"/> Trichomonas                 | _____ |
| <input type="checkbox"/> Cytomegalovirus disease     | <input type="checkbox"/> Hydrosalpinx              | <input type="checkbox"/> Uterine polyps              | _____ |
| <input type="checkbox"/> DES Exposure in utero       | <input type="checkbox"/> Incontinence              | <input type="checkbox"/> Uterine prolapse            | _____ |
| <input type="checkbox"/> Dysplasia (abnormal paps)   | <input type="checkbox"/> Infertility               | <input type="checkbox"/> Uterine scar tissue         | _____ |
| <input type="checkbox"/> Dysfunctional Bleeding      | <input type="checkbox"/> Irregular menses          |  | _____ |

Comments: \_\_\_\_\_

**REPRODUCTIVE & MENSTRUAL HISTORY:**

Total # of pregnancies	# of Full Term	# of premature pregnancies	# of terminations	# of miscarriages	# of ectopics	# of multiple births	# living

Date of last menstrual period: \_\_\_\_\_

Certainty of last menstrual period: \_\_\_\_\_

Menopause status: \_\_\_\_\_

Home pregnancy test: \_\_\_\_\_

Method of birth control: \_\_\_\_\_

On hormone replacement: \_\_\_\_\_

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## Patient Health History Questionnaire

**PAST SURGICAL HISTORY:**     None

- |   |  |  |       |
|---|--|--|-------|
| <input type="checkbox"/> Adenoidectomy                | <input type="checkbox"/> Cystoscopy                | <input type="checkbox"/> Laparoscopy                 | _____ |
| <input type="checkbox"/> Appendectomy                 | <input type="checkbox"/> D&C                       | <input type="checkbox"/> LASIK (eye correction)      | _____ |
| <input type="checkbox"/> Back surgery                 | <input type="checkbox"/> Ectopic Pregnancy         | <input type="checkbox"/> LEEP (Cervical Cone biopsy) | _____ |
| <input type="checkbox"/> Breast augmentation          | <input type="checkbox"/> Endometrial ablation      | <input type="checkbox"/> Ovary Removal               | _____ |
| <input type="checkbox"/> Breast lumpectomy            | <input type="checkbox"/> Gastric Bypass            | <input type="checkbox"/> Pacemaker implant           | _____ |
| <input type="checkbox"/> Breast mastectomy            | <input type="checkbox"/> Hemorrhoid                | <input type="checkbox"/> Shoulder surgery            | _____ |
| <input type="checkbox"/> Bladder lift                 | <input type="checkbox"/> Hernia                    | <input type="checkbox"/> Sinus surgery               | _____ |
| <input type="checkbox"/> C/Section                    | <input type="checkbox"/> Hip replacement           | <input type="checkbox"/> Splenectomy                 | _____ |
| <input type="checkbox"/> CABG ( coronary bypass)      | <input type="checkbox"/> Hysteroscopy              | <input type="checkbox"/> Thyroidectomy               | _____ |
| <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Hysterectomy (abdominal)  | <input type="checkbox"/> Tonsillectomy               | _____ |
| <input type="checkbox"/> Cholecystectomy/Gallbladder) | <input type="checkbox"/> Hysterectomy (vaginal)    | <input type="checkbox"/> Tubal ligation              | _____ |
| <input type="checkbox"/> Colon resection              | <input type="checkbox"/> Hysterectomy-laparoscopic |  | _____ |
| <input type="checkbox"/> Colonoscopy                  | <input type="checkbox"/> Knee surgery              |  | _____ |

Comments: \_\_\_\_\_

**GENETIC HISTORY:**     None

- |   |  |  |       |
|---|--|--|-------|
| <input type="checkbox"/> Baby with birth defects    | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Tay-Sachs disease | _____ |
| <input type="checkbox"/> Chromosomal disorder       | <input type="checkbox"/> Mental retardation      | <input type="checkbox"/> Thalassemia       | _____ |
| <input type="checkbox"/> Cystic fibrosis            | <input type="checkbox"/> Muscular dystrophy      |  | _____ |
| <input type="checkbox"/> Down's Syndrome            | <input type="checkbox"/> Neural tube defects     |  | _____ |
| <input type="checkbox"/> Fragile X                  | <input type="checkbox"/> Sickle cell anemia      |  | _____ |
| <input type="checkbox"/> Genetic/Inherited disorder | <input type="checkbox"/> Spinal Muscular Atrophy |  | _____ |

Comments: \_\_\_\_\_

**MEDICATIONS:**     None

	Medication	Dosage	Frequency	Reason
1.				
2.				
3.				
4.				
5.				
6.				

**ALLERGIES:**     None

	Medication or Substance	Reaction		Medication or Substance	Reaction
1.			3.		
2.			4.		

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

## Patient Health History Questionnaire

**FAMILY HISTORY:**     None

	<u>Age</u>	<u>Heath Problem or cause of death</u>
Father:	_____	_____
Mother:	_____	_____
Siblings:	_____	_____
	_____	_____
	_____	_____
Children:	_____	_____
	_____	_____
	_____	_____
Uncles / Aunts:	_____	_____
	_____	_____
Grandparents:	_____	_____
	_____	_____
	_____	_____
	_____	_____

**GENERAL HEALTH SCREENING:**

Date of last Pap smear: _____	Date of last Colonoscopy: _____
Date of last Mammogram: _____	Date of last Bone Density Scan: _____

	<u>Yes</u>	<u>No</u>	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how much? _____ and for how long? _____
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how much? _____ and for how long? _____
Do you drink regularly?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how many drinks per week? _____
Do you smoke marijuana ?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how many joints per week? _____
Do you use other recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If so, which ones? _____
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you perform monthly breast exam?	<input type="checkbox"/>	<input type="checkbox"/>	
Is your diet low in fat?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use seat belts?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you ingest 1000mg of Calcium a day?	<input type="checkbox"/>	<input type="checkbox"/>	

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## Patient Health History Questionnaire

Instructions: Please circle "Y" to those that apply to YOU and/or YOUR FAMILY (on both your **mother's** or **father's** side). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions.

### BREAST AND OVARIAN CANCER

<u>Yes</u>	<u>No</u>	<u>RELATIONSHIP</u>	<u>AGE AT DIAGNOSIS</u>
<input type="checkbox"/>	<input type="checkbox"/>	- Breast cancer before 50	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Ovarian cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Breast cancer in both breast or multiple primary breast cancers	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Both breast & ovarian cancer (in an individual or family)	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Male breast cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	- 2 or more breast or ovarian cancers (in an individual or family)	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer	_____

### COLON AND UTERINE CANCER

<u>Yes</u>	<u>No</u>	<u>RELATIONSHIP</u>	<u>AGE AT DIAGNOSIS</u>
<input type="checkbox"/>	<input type="checkbox"/>	- Uterine cancer before 50	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Colorectal cancer before 50	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Both uterine & colorectal cancer (in an individual or family)	_____
<input type="checkbox"/>	<input type="checkbox"/>	- 2 or more uterine or colorectal cancers (in an individual or family)	_____
<input type="checkbox"/>	<input type="checkbox"/>	- Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain or small bowel cancer (in an individual or family)	_____

### COLON POLYP HISTORY

<u>Yes</u>	<u>No</u>	<u>RELATIONSHIP</u>	<u>AGE AT DIAGNOSIS</u>
<input type="checkbox"/>	<input type="checkbox"/>	- 10 or more colon polyps found in lifetime	_____