STANTON GYNECOLOGY, LLC HEALTH QUESTIONNAIRE

(Please Print)

Today's date:	Age:	Date of Birth:	
Patient's last name:		First name:	MI:

Reason for your visit today:

Current Medical Conditions:

PAST MEDICAL HISTORY (please circle)

Cancer –BRCA Tested	Eyes- Vision Loss/Macular Degeneration	Neurology – Seizures / Epilepsy
Cancer - Breast	GI - Colon Polyps	Neurology – Stroke / TIA
Cancer - Cervical	GI – Crohn's / ulcerative Colitis	Ortho – Chronic back pain
Cancer - Colon	GI – Gallbladder Disease	Ortho – Degenerative Joint Disease
Cancer – Endometrial	GI -Hemorhoids	Ortho – Fractures
Cancer – Lung	GI – Irritable Bowel Syndrome	Ortho - Other
Cancer – Other	GI – Liver Disease / Hepatitis	Psych - ADD
Cancer – Ovary	GI - Other	Psych – Anxiety Disorder
Cancer – Skin	GI – Reflux / Stomach Ulcers	Psych – Bipolar Disease
Cancer – Vaginal	GI – Vitamin D Deficiency	Psych - Depression
Cancer – Vulvar	Hematology - Anemia	Psych – Eating Disorder
Cardiac - Heart Arrhythmia	Hematology – Bleeding Disorder	Psych – Other
Cardiac – High Blood Pressure	Hematology – Blood Clotting Disorder / Factor V Leiden	Psych – PMS / PMDD
Cardiac – High Cholesterol	Hematology – Blood Transfusion	Pulmonary – Asthma
Cardiac – Other	Hematology – DVT /Pulmonary Embolism	Pulmonary – COPD /Emphysema
Dermatology – Acne	Hematology - Other	Pulmonary - Other
Dermatology –Eczema / Psoriasis	ID - Chicken Pox / Shingles	Pulmonary – Seasonal Allergies / Allergic Rhinitis
Dermatology - Other	ID – HIV	Pulmonary – Sleep Apnea
ENT – Hearing Loss	ID – MRSA	Rheumatology - Arthritis
ENT - Other	ID - Other	Rheumatology – Autoimmune Disease
Endocrinology – Diabetes/History of Gestational Diabetes	ID – Rheumatic fever	Rheumatology – Fibromyalgia / Chronic Pain
Endocrinology - Elevated Prolactin	ID – Tuberculosis / Positive PPD	Rheumatology – Other
Endocrinology - Osteoporosis	ID – Usual childhood diseases	Rheumatology – Restless Leg Syndrome
Endocrinology - Other	Neurology – Headaches / Migraines	Urology – Frequent Urinary Tract Infections
Endocrinology –Thyroid Problems	Neurology – Memory Loss / Dementia	Urology – Hematuria (blood in urine)
Eyes - Other	Neurology – Other	Urology – Interstitial Cystitis

Urology – Kidney Disease	**Wt Management - Obesity**	
Urology – Kidney Infection	**Wt Management-Other**	
Urology – Kidney Stones		
Urology – Other		
Urology – Urinary Incontinence		

SURGICAL HISTORY

Date:	**Type:**	**Physician:**
Date:	**Type:**	**Physician:**
Date:	**Type:**	**Physician:**
Date:	**Type:**	**Physician:**
Date:	**Type:**	**Physician:**
Date:	**Type:**	**Physician:**
Date:	**Type:**	**Physician:**

Current Med Prescribed by Our Office:	**Other Meds you are currently taking:**

Allergies and Reactions:

GYNECOLOGICAL HISTORY

Date of Last Menstrual Period?	**How often do your menstrual periods occur?**
Is the Flow: Light Moderate Heavy	**How long do your menstrual periods last?**
Cramps with periods : Yes No	**At what Age did you begin menstruation?**
If postmenopausal, age at Menopause	
Do you have any history of Sexually Transmitted Diseases? Yes No If yes, which:	
Date of Last Pap:	**Date of Last Mammogram:**
History of Abnormal Paps:	**History of Abnormal Mammograms:**
Date of Last Colonoscopy:	**Date of Last Dexa:**
Do you perform Self Breast Exams? Yes No	**Do you have any Vaginal Itching? Yes No**
Any Pain or Bleeding during intercourse? Yes No	**Are you sexually active? Yes No**
Sexual Orientation : Heterosexual / Homosexual Bi- Sexual	**How Many Life time Partners : More than 5 Less than 5**
Current Birth Control method:	

FAMILY HISTORY

	Age	If Living-please list serious medical conditions & onset Age	Age at Death	Cause of Death
Father				
Mother				
Brother				
Sister				
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				

GENERAL MEDICAL HISTORY/REVIEW OF SYSTEMS

Smoking Status: Never / Former / Current / Occasional **How much per day?** **Years of use:**

Alcohol Intake: None / Occasional / Moderate / Heavy **If applicable:**
Use Pre-Pregnancy? Yes / No

Illegal Substance: None / Occasional / Moderate / Heavy **If applicable:**
Use Pre-Pregnancy? Yes / No

Caffeine Intake: None / Occasional / Moderate / Heavy **If applicable:**
Use Pre-Pregnancy? Yes / No

Exercise Level: Low Med High | **General Stress Level :** Low Med High

Diet: Regular/Vegan/Specific / Vegetarian/Carbohydrate/ Gluten free/Cardiac/Diabetic

Marital Status: Single / Mar / Div / Sep / Wid

Any history of Domestic Violence? Yes / No

Education: **Occupation:**

Religion: **Seat belts used routinely:** Yes No

Is a blood transfusion acceptable in emergency? Yes / No

VACCINE HISTORY

Date:	Type:
Date:	Type:
Date:	Type:
Date:	Type:
Date:	Type:
Date:	Type:

PRIMARY CARE PHYSICIAN:

OBSTETRICAL HISTORY		
How many times have you been pregnant?	**How many children do you have? Age at first child:**	
Any miscarriages? Yes No How Many?	**Any abortions? Yes No How Many?**	
Any Ectopic Pregnancies?	**Any Premature Deliveries?**	
Have you had any of the following complications during pregnancy, delivery or post delivery care:		
High Blood Pressure? Yes No	**Diabetes? Yes No**	**Pre-Term Labor? Yes No**
Infection? Yes No	**Bleeding? Yes No**	**Depression? Yes No**
Cesarean Section? Yes No	**Anemia? Yes No**	
To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect or incomplete information can be dangerous to my health. I acknowledge and agree it is my responsibility to inform Stanton Gynecology, LLC of any changes in my medical status prior to receiving medical treatment. I also authorize the healthcare staff to perform and order any necessary services I may need.		
Patient/Guardian signature		*Date*

OTHER INFORMATION I FEEL IMPORTANT TO PROVIDE:

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