ROPER ST. FRANCIS
PHYSICIAN PARTNERS

Today's Date ________________

Thank you for choosing Partners OB/GYN. Please fill out this questionnaire completely, as best you can.

Name: ____ Date of Birth: ________________

Reason for this visit: ____

Referred by:___________________________ Primary Care Provider:_______________________

Menstrual History: (Complete even if post-menopausal or no longer having periods)

Age at first period: ____________ years

First day of your last menstrual period _______________________________ (MM/DD/YY)

If your menstrual periods are regular; periods start every ___________days.

If your menstrual periods are irregular; periods start every ________to________ days (e.g. 12 to 60)

Duration of bleeding: __________ days Heavy Flow? Yes_________ No__________

Is pain associated with periods? Yes_________ No_________ Occasionally_________

If yes, is it: before menses? _________ during menses? _________ both? _________

Does bleeding or spotting occur between periods? Yes_________ No_________

Does bleeding or spotting occur after intercourse? Yes_________ No_________

Any bleeding/spotting since going through Menopause (if applicable) Yes_________ No___________

GYN History:

Date of last pap smear: ____________

Have you had abnormal pap smears? Yes_________ No_________

What treatment for abnormal paps? None______ Repeat Paps______ Cryotherapy______ Laser______

Cone Biopsy_______ Loop Excision (LEEP) ______ Other___________

Have you received the HPV vaccination (Gardasil)? Yes________ No________

Have you been diagnosed/treated for an STI/STD in the past? Yes________ No________

If Yes, Which?____

Date of last mammogram: ___________________ (MM/YY)

Have you had an abnormal mammogram? Yes_________ No_________

Have you ever had a breast biopsy? Yes________ No________

Date of last Bone Density:____________________ Date of last Colonoscopy:_____________________

Contraception:

What method of contraception are you currently using?____

What other methods have you used in the past?____

Method	Brand Name	Date of Usage	Reason for stopping?
Birth Control Pills			
IUD/Implants			
Condoms			
Other			

Obstetrical History:

Total # of pregnancies: _______________ Total # of term deliveries: _______________
Total # of pre-term deliveries: _______________ Total # of living children: _______________
Total # of induced abortions: _______________ Total # of miscarriages: _______________

Date	**Gender**	**Weight**	**Length of pregnancy** (Full or # of weeks)	**Delivery Type** (Vaginal, c-section, vacuum, forceps)	**Complications**

Name: ____ Date: ___________________________________

Medical History:

Condition	**Details/Explanation**	**Condition**	**Details/Explanation**
_____Diabetes		____Chronic Headaches/ Migraines	
_____Kidney Disease		____Mood/Emotional Problem	
_____Recurrent UTIs		____Thyroid Problem/Goiter	
_____High Blood Pressure		____Asthma/Pneumonia	
_____Liver Disease/Hepatitis		____Glaucoma	
_____Heart Problems		____Tuberculosis	
_____Blood Disorders/Anemia		____Arthritis/Bone Problems	
_____Epilepsy/Seizures		____Nerve Problems	
_____Toxin/Radiation Exposure		____Other_______________________________________	

Medications – Prescription and Over the Counter (OTC) Attach additional sheets as necessary

Name of Medicine	**Dosage Strength**	**Frequency of use**	**Reason or indication**

Allergies/Intolerances:

Please list any allergies to drugs or substances below

Drug/Substance	**Reaction and severity**

Questions about your lifestyle:

o you use tobacco products? ___________Amount used and length of use: ________________________________
Do you use alcoholic beverages? _________How much? ______________How often? ________________________
Type of alcoholic beverage used: _____________________________________

Do you use “recreational drugs”? ___________Please describe: ____
Do you exercise regularly? How many days per week?____

Hospitalizations & Surgeries:

Date	**Procedure/Reason for Hospitalization**	**Complications/Findings**

Health of Close Relatives:
(Parents, sisters & brothers; grandparents, aunts & uncles, if significant)

Relationship	**Name**	**Date of Birth**	**Current health (if living)**	**Significant health problems**
Father				
Mother				