TORRANCE MEMORIAL
PHYSICIAN NETWORK

Today's Date: _____

OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

A NAME: _____ **AGE:** _____ **DOB:**_____

1. Marital Status: ☐ Single ☐ Married ☐ Long-term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit:_____
3. Referring Physician: _____
4. Occupation:_____
5. Preferred phone number:_____

B MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

1. Age of first period: _____ years.
2. If your Menstrual periods are regular; periods start every: _____ days.
3. If your Menstrual periods are irregular; periods start every: _____ to _____ days. (e.g., 12 to 60)
4. Duration of bleeding: _____ days.
5. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
6. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
7. First day of last Menstrual period: _____
8. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally
9. If yes, is it: ☐ before menses ☐ during menses ☐ both

C PREGNANCY HISTORY (ALL PREGNANCIES) ☐ HAVE NEVER BEEN PREGNANT

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of Delivery or Termination	Duration Pregnancy	Hours of Labor	Type of Delivery	Note Complications Mother and/or Infant • Preeclampsia • Gestational Diabetes • Premature Labor • Other / Specify	(Child) Sex	(Child) Birth Weight	(Child) Present Health

D BIRTH CONTROL HISTORY

What birth control method(s) do you currently use?_____

E SEXUAL HISTORY

1. Do you have a sexual partner? ☐ No ☐ Yes: ☐ Male ☐ Female
2. Are there concerns about your sexual activity which you may want to discuss with your doctor?
   ☐ Yes ☐ No

F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES: Check any that apply or ☐ None

Surgery	Year	Surgery	Year
☐ D&C	_____	☐ Ovarian Surgery	_____
☐ Hysteroscopy	_____	☐ L cyst(s) removed ovarian	_____
☐ Infertility Surgery	_____	☐ R cyst(s) removed ovarian	_____
☐ Tuboplasty	_____	☐ L ovary removed	_____
☐ Tubal Ligation	_____	☐ R ovary removed	_____
☐ Laparoscopy	_____	☐ Vaginal or bladder repair for prolapsed or incontinence	_____
☐ Hysterectomy (vaginal)	_____	☐ Cesarean section	_____
☐ Hysterectomy (abdominal)	_____	☐ Other (specify)_____	_____
☐ Myomectomy	_____	_____	_____

G PAST SURGICAL HISTORY (NOT OB/GYN): List all surgeries and their year or ☐ None

Surgery	Mo/Year	Complications

H PAP SMEAR/MAMMOGRAM HISTORY

1. Date of last pap smear:_____: ☐ Normal ☐ Abnormal
2. Have you had abnormal pap smears? ☐ No ☐ Yes
3. Have you had treatment for abnormal smear? ☐ No ☐ Yes
4. If yes, what type(s) of treatment have you had?

Treatment	Year	Treatment	Year
☐ Cryotherapy	_____	☐ Cone Biopsy	_____
☐ Laser	_____	☐ Loop excision (LEEP)	_____

5. Date of last mammogram:_____
6. Have you had an abnormal mammogram? ☐ No ☐ Yes

OTHER PAST GYNECOLOGICAL HISTORY: Check any that apply or ☐ None

☐ Venereal warts	☐ Herpes-genital	☐ Syphilis	☐ Pelvic Inflammatory Dis.
☐ Endometriosis	☐ Chlamydia	☐ Gonorrhea	☐ Vaginal Infections
☐ HPV	☐ Other (specify) _____		

I PAST MEDICAL HISTORY: Check any that apply or ☐ None

☐ Arthritis
☐ Diabetes:
- ☐ Diet controlled
- ☐ Pill controlled
- ☐ Insulin controlled
- ☐ Gestational

☐ High Blood Pressure
☐ Breast Cancer
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease, includes hepatitis
☐ Epilepsy
☐ Eating Disorder
☐ Heart Disease
☐ Blood Clots Leg/Thigh
☐ Asthma
☐ Cancer (specify) _____
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Blood Transfusions
☐ Thyroid Disease
☐ Other (specify)
_____
_____
_____

J CURRENT MEDICATIONS (include dose/amount per day)

Medication	Dose	Frequency

K DO YOU CURRENTLY?

Smoking: ☐ Never ☐ Former ☐ Yes, Packs/Day:_____ Years Smoked:_____ ☐ Cigarettes ☐ VAP ☐ Hooka

Alcohol: ☐ Never ☐ Former ☐ Yes, Drinks/Week:_____ Type:_____

Illicit Drugs: ☐ Never ☐ Former ☐ Yes Type:_____

Caffeine Intake: ☐ Yes ☐ No
☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate Daily Intake:_____

Lifestyle: Are you on a specific diet? ☐ Yes ☐ No If yes, which type of diet: _____
Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise: _____
Days/Week:_____ Hours/Day: _____

L DRUG ALLERGIES ☐ NO ☐ YES, LIST:

_____
_____

M FAMILY HISTORY or ☐ None

	Yes	Deceased *(Note age & cause)*	Affected Relatives *(Father, Mother, Brother, Sister, Son, Daughter)*
Diabetes	☐	_____	_____
Ovarian Cancer	☐	_____	_____
Heart Disease	☐	_____	_____
Endometrial Cancer	☐	_____	_____
Breast Cancer	☐	_____	_____
Colon Cancer	☐	_____	_____
Other/Specify	☐	_____	_____

N OTHER SYMPTOMS or PROBLEMS: Check any that apply or ☐ None

☐ Weight Loss
☐ Weight Gain
☐ Breast Discharge
☐ High Cholesterol
☐ Hair Growth
☐ Hair Loss
☐ Hot Flushes/Flashing
☐ Physical Abuse/Domestic Violence
☐ Change in Energy
☐ Change in Exercise Tolerance
☐ Change in Urinary Function
☐ Other (specify)_____

O **COMPLETE ONLY IF YOU ARE PREGNANT or PLANNING TO BE PREGNANT IN THE NEAR FUTURE**
Have you or the baby's father or anyone in our families ever had the following:

Down Syndrome (Mongolism)? If yes, who? _____

Other Chromosomal abnormality? If yes, specify _____

Neural tube defect (spina bifida, anencephaly)? If yes, who? _____

Hemophilia or other coagulation abnormality? If yes, who? _____

Muscular Dystrophy? If yes, who? _____

Cystic Fibrosis? If yes, who? _____

If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

Father Result _____

Mother Result _____

If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?

Father Result _____

Mother Result _____

If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalessemia?

Father Result _____

Mother Result _____

If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?

Father Result _____

Mother Result _____

_____

PATIENT SIGNATURE DATE