

# Women's Health Center Patient Questionnaire



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

Have you had any of the following in the past 30 days:

### General

- Stress
- Fatigue (feeling tired or weak)
- Weight gain
- Unexplained weight loss
- Safety concerns

### Breast

- Lumps
- Pain
- Nipple discharge

### Skin/Hair

- Lumps
- Skin changes
- Hair changes

### Respiratory

- Wheezing
- Shortness of breath
- New cough

### Heart/Circulation

- Irregular heartbeat
- Chest pain
- Edema/swelling
- Calf pain

### Gastrointestinal

- Abdominal pain or bloating
- Changes in bowel movements
- Heartburn
- Nausea or vomiting

### Genitourinary

- Blood in urine
  - Frequent urination
  - Pain with urination
  - Incontinence (leaking urine)
    - with urge to urinate
    - with cough, sneeze, or laugh
- If yes, is this bothering you? Y / N
- Abnormal vaginal discharge or bleeding
  - Painful intercourse
  - Change in libido

### Musculoskeletal

- Arthritis
- Back pain
- Joint pain or swelling
- Bone fractures
- Weakness

### Neurological

- Confusion
- Headaches
- Changes in memory
- Seizures
- Numbness or tingling in hands or feet

### Psychiatric

- Depression
- Anxiety

### Hematology

- Swollen lymph nodes
- Easy bruising or bleeding

### Endocrine

- Abnormal blood sugars
- Thyroid problems

Please list any other symptoms you're having that are not listed above:

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<b>GYN History</b>
Age at first period: _____
Period comes every _____ days
Painful periods? <input type="checkbox"/> Yes <input type="checkbox"/> No Heavy periods? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you have a history of the following:</b>
Pelvic or sexually transmitted infections: <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal paps: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical procedures: <input type="checkbox"/> Yes <input type="checkbox"/> No
Hot flashes or night sweats: <input type="checkbox"/> Yes <input type="checkbox"/> No
Menopausal symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Age at last period: _____ Date of last period: _____
Current Contraception: _____

<b>Sexual History</b>
Have you been sexually active in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many partners in the last year? _____
Is your partner: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both
How long have you been with your current partner? _____
Have you been sexually or physically abused? <input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to talk with us about this during today's visit? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Social History</b>
Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit If yes, how many drinks per week _____
Other Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>OB History</b>
Have you ever been pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please indicate all that apply:
Total number of pregnancies: _____
<input type="checkbox"/> Vaginal births: _____ (total number)
<input type="checkbox"/> Cesarean sections: _____ (total number)
<input type="checkbox"/> Miscarriages: _____ (total number)
<input type="checkbox"/> Tubal pregnancies: _____ (total number)
<input type="checkbox"/> Pregnancy terminations _____ (total number)
<input type="checkbox"/> Still births: _____ (total number)
<input type="checkbox"/> Number of living children: _____ (total number)

<b>Family History</b>
<input type="checkbox"/> Breast Cancer Who: _____ Age _____
<input type="checkbox"/> Ovarian Cancer Who: _____ Age _____
<input type="checkbox"/> Uterine Cancer Who: _____ Age _____
<input type="checkbox"/> Other Cancer Who: _____ Age _____
<input type="checkbox"/> Blood clots or stroke Who: _____ Age _____
<input type="checkbox"/> Heart Disease Who: _____ Age _____
<input type="checkbox"/> Osteoporosis Who: _____ Age _____
<input type="checkbox"/> Other Who: _____ Age _____

**Surgeries:** Please list all surgeries (e.g. tonsillectomy, tubal ligation) with the approximate year you had each one:

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**Past Medical History:** Please check all that apply.

<input type="checkbox"/> Blood clots in legs, lungs	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes in pregnancy	<input type="checkbox"/> Uterine fibroid	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Ovarian tumor
<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Liver or gall bladder problems	

Please list any other medical conditions you've had that are not listed above.

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