OBGYN OF LANCASTER

Annual Questionnaire

MRN#:

Patient Phone Numbers:

Patient Name: DOB: Age: Date:

REASON FOR YOUR VISIT TODAY?

PRIMARY CARE PHYSICIAN:_____

OTHER PHYSICIAN(S):_____

CURRENT MEDS AND DOSE: ☐ None

_____

_____

_____

_____

HERBAL SUPPLEMENTS/ OVER THE COUNTER MEDS: ☐ None

_____

_____

_____

_____

Last Colon Cancer Screening: _____

Last Mammogram: _____

Last Osteoporosis Screen: _____

Last Cholesterol Screening: _____

Last PAP Smear: _____

ALLERGIES: ☐ None

_____

_____

_____

Do you have an allergy to LATEX? ☐ No ☐ Yes

MEDICAL HISTORY: ☐ None

- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Infertility
- ☐ GI Disease _____
- ☐ Kidney Stones
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ GERD
- ☐ Endometriosis
- ☐ Depression/Anxiety/OCD/ADHD
- ☐ Blood Clots (legs/lungs)
- ☐ Gestational Diabetes
- ☐ Asthma
- ☐ Mitral Valve Prolapse
- ☐ **Abnormal PAP Smears/Dysplasia**
- ☐ STD
- ☐ Osteoporosis/Osteopenia
- ☐Other_____

_____

SURGICAL HISTORY: ☐ None PLEASE PROVIDE YEAR OF SURGERY IF POSSIBLE

- ☐ Wisdom Teeth
- ☐ Tonsillectomy
- ☐ Thyroid
- ☐ Breast Biopsy /Lumpectomy
- ☐ Breast Mastectomy
- ☐ Colonoscopy/Endoscopy
- ☐ Heart Surgery
- ☐ Bladder Surgery
- ☐ Gall Bladder removed
- ☐ Appendectomy
- ☐ Hysterectomy (uterus only)
- ☐ Ovaries removed
- ☐ Cesarean Section
- ☐ Laparoscopy
- ☐ Hysteroscopy
- ☐ Tubal Ligation/Essure
- ☐ D&C / D&E
- ☐ LEEP / CONE
- ☐ Joint/Bone
- ☐ Cosmetic Procedure
- ☐ Other: _____

_____

Have you ever had a blood transfusion?
☐ Yes ☐ No

OBSTETRICAL HISTORY: ☐ None

Number Pregnancies: _____

Number Living Children_____

Number Vaginal Deliveries_____

Number C/Sections _____

Pregnancy Complications (please explain):

_____

_____

_____

GYNECOLOGIC REVIEW OF SYMPTOMS:

Age of First Period_____

First day of Last Period_____

Flow lasts _____ days

Number of days from the beginning of one period to the beginning of the next period: _____days/mos.

Current Contraception: ☐ None

☐ Pills ☐ Patch ☐ Tubal ☐ Essure

☐ Mirena/Paragard ☐ Nuvaring ☐ Depo

☐ Condom ☐Vasectomy ☐ Implanon

☐ None ☐ PMS ☐ Painful periods ☐ Heavy Periods ☐ Spotting between periods ☐ Pain w/ Intercourse ☐ Low Libido

PLEASE TURN PAPER OVER FOR ADDITIONAL QUESTIONS. THANK YOU

SOCIAL HISTORY:	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco Use: ☐ No ☐Yes AMOUNT_____ / HOW LONG USED? _____
Alcohol Use: ☐ No ☐Yes HOW MANY DRINKS / WEEK_____
Drugs Use: ☐ No ☐Yes TYPE_____ TIMES/ WEEK_____
Domestic Violence: ☐ No ☐Yes ☐ Mental ☐ Physical ☐ Sexual
Sunscreen Use: ☐ No ☐Yes
Seat Belt Use: ☐ No ☐Yes
Sexual Preference ☐ Male ☐Female
Reg. Exercise: ☐ No ☐ Yes Type
_____

Occupation:
_____

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

FAMILY HISTORY :	☐ None	PLEASE INDICATE WHICH FAMILY MEMBER IS AFFECTED BY THE ILLNESS

☐ Hypertension_____
☐ Diabetes_____
☐ Macular Degeneration_____
☐ Heart Disease_____
☐ Osteoporosis_____
☐ High Cholesterol_____

☐ Birth Defects _____
☐Stroke_____
☐Breast Cancer_____
☐Uterine Cancer_____
☐Ovarian Cancer_____
☐Cervical Cancer_____

☐ Blood Clots (legs/lungs)_____
☐ Alzheimer's/Parkinson's _____
☐ Colon Cancer _____
☐ Other Cancer_____
☐ Other Disease _____
_____

REVIEW OF SYSTEMS:	Please check all that apply		If you have none of these symptoms, please check ☐ none		
General ☐none	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue	
Eyes ☐none	☐ Glaucoma	☐ Glasses/contacts	☐ Cataracts	☐ Blurry Vision	
ENT ☐none	☐ Ulcers	☐ Sinusitis	☐ Ringing in ears	☐ Headache	
Heart ☐none	☐ Irregular heart rate	☐ Chest pain	☐ Shortness of Breath with exercise	☐ Shortness of Breath lying down	
Respiratory ☐none	☐ Cough	☐ Wheezing	☐ Coughing up Blood	☐ Short of breath	☐ Pain w/Breathing
GI ☐none	☐ Diarrhea ☐Nausea	☐ Constipation ☐ Leaking of Stool	☐ Bloody stool ☐ Irritable Bowel	☐ Black stool ☐Vomiting	☐ Excessive Gas
Urinary ☐none	☐ Urgency ☐ Feeling bladder not emptying	☐ Frequency ☐ Leaking of urine	☐ urination at night ☐ Leaking of urine with coughing, laughing, sneezing	☐ Blood in Urine	☐ Pain with urination ☐ Leaking of urine when urge to go
Muscle/Bone ☐none	☐ weakness	☐ Joint Pain	☐ Swelling	☐ Fibromyalgia	☐ Back Pain
Skin/breast ☐none	☐ Breast Pain	☐ Breast Discharge	☐ Rash	☐ Masses	☐ Skin Ulcers
Neurologic ☐none	☐ Dizziness	☐ Seizures	☐ Trouble walking	☐ Numbness	☐ Headaches
Psychiatric ☐none	☐ Depression	☐ Crying	☐ Anxiety	☐ ADD / ADHD	
Endocrine ☐none	☐ Diabetes	☐ Hypothyroid	☐ Hyperthyroid	☐ hot flashes	☐ night sweats
Blood ☐none	☐ Bruises	☐ Unusual Bleeding	☐ Enlarged nodes		

When was your last immunization for:	Rubella Date_____	Tetanus Date_____	Pneumoccoccal (Pneumonia) Date_____	Hepatitis B Date_____	HPV Date_____

We use the latest Pap technology called Thin Prep and HPV testing. If your insurance company does not cover these tests, you may be responsible for the costs. If you choose not to use this technology we can process the PAP in the conventional manner.

☐ I decline to have my Pap smear processed by the Thin Prep/HPV Method _____ (Please Initial)

To the best of my knowledge, the above information is correct_____ _____/____/_____
Patient Signature Date

Reviewed by: _____ Date: _____/____/_____