COURI CENTER
for Gynecology and Integrative Women's Health

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Gynecological Questionnaire

Date ______________

Name ____

Address ______________________________ **Home Telephone** ( ) ____________________

City ______________ **State** _____ **Zip** __________ **Cell Telephone** ( ) ____________________

Patient employed by ______________________ **Business Telephone** ( ) ____________________

Date of Birth ______________ **Age** __________ **Husband's Name** ____________________

❑ **Single** ❑ **Married** ❑ **Separated** ❑ **Divorced** ❑ **Widowed**

Referred by Doctor: ______________________ **Another Patient** ______________ **Self** ____

I. Please discuss the main reason for your coming to the office today:

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II. MEDICAL HISTORY – Please check items applicable to you

Previous GYN Surgeries

❑ Cryocautery
❑ D & C
❑ Cesarean Section
❑ Removal of Ovarian Cyst
❑ Infertility Surgery
❑ Removal of one or both Ovaries
❑ Colposcopy
❑ Laparoscopy
❑ Breast Biopsies
❑ Laparoscopic Sterilization
❑ Postpartum Sterilization
❑ Removal of Tubal Pregnancy
❑ Hysterectomy ❑ Abdominal ❑ Vaginal
❑ Bladder Repair ❑ Abdominal ❑ Vaginal
❑ Other

Other Surgeries: ______________________

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Medical Allergies: ______________________

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Complications: ______________________

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Currently taking these Medications: **(Name / Dosage / How Often)**

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Are you or have you been sexually active? yes no

Current contraceptive method

❑ None ❑ Foam ❑ Condoms ❑ Diaphragm ❑ Sterilization ❑ Vasectomy ❑ Tubal Ligation

❑ IUD: Type ______________________ Insertion Date: ______________________

❑ Birth Control Pills: Type ______________________________ ❑ 21-Day ❑ 28-Day

Side Effects: ❑ Daily Headaches ❑ Migraines ❑ High Blood Pressure ❑ Phlebitis (blood clot in legs)

III. FEMALE HISTORY

Age at first Period ______________ Current Menstrual Cycle occurs every _______ days, lasting ________ days

Age at Menopause______________ Flow is ❑ Light ❑ Moderate ❑ Heavy ❑ Clots

I have: ❑ Cramps with my periods I have: ❑ Pain with intercourse

❑ Spotting or bleeding between periods

Did your mother take Stilbesteral (DES) ? ❑ yes ❑ no

Have you had: ❑ Vaginal Herpes ❑ Venereal Warts ❑ Gonorrhea ❑ Syphilis ❑ HIV

No.	Year	Months Pregnant	Pregnancies: Type of Delivery (Delivery, Miscarriage or Abortion)	Complications (Miscarriages, etc.)
1.				
2.				
3.				
4.				
5.				
6.				

IV. PERSONAL HISTORY – Please check if you have had or currently have problems with the following:

❑ Back ❑ Hair ❑ Sexual Relationship ❑ Sleeping
❑ Migraines ❑ TB ❑ Toxemia ❑ Loss of Urine when coughing or sneezing
❑ Daily Headaches ❑ Asthma ❑ Stomach Ulcer ❑ Blood Clots in legs or lungs
❑ Thyroid Disease ❑ Heart Murmur ❑ Gallstones or Attacks ❑ Fractured Pelvic Bones ❑ Endometriosis
❑ Cystic Mastitis ❑ Rheumatic Fever ❑ Hepatitis ❑ Diabetes ❑ Osteoporosis
❑ Breast Lumps ❑ High Blood Pressure ❑ Urinary Tract Infection ❑ Anemia ❑ Malignancy
❑ Female Organs ❑ Previous IUD ❑ Depression ❑ Hands, Feet ❑ Bowels
❑ Weight ❑ Pelvic Infection ❑ Bladder ❑ Digestion ❑ Rectum
❑ Epilepsy ❑ Heart ❑ Breathing ❑ Joints, muscles ❑ Other

Date of Last:

Pap Smear ______________________ Menstrual Period ________________ Mammogram ___________________________

Blood Count ____________________ Blood Sugar ____________________ Rubella Titer (for German Measles) ________

TB Skin Test ____________________ Chest X-Ray ____________________ EKG ____________________________________

My height is ____________________ My usual weight is ______________ Do you exercise? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No If yes, how much? ____________________

Do you use alcohol? ❑ Yes ❑ No If yes, how much? ________________

V. FAMILY HISTORY – Please check if your children, brothers, sister, parents or grandparents have had the following:

❑ TB ❑ Heart Disease ❑ High Blood Pressure ❑ Diabetes ❑ Osteoporosis
❑ Twins ❑ Genetic Disease ❑ Stroke ❑ Leukemia ❑ Endometriosis
❑ Blood Disease ❑ Colon Cancer

Female Cancer: ❑ Cervix ❑ Uterus ❑ Ovaries ❑ Breast ❑ Tubal