COURI CENTER
for Gynecology and Integrative Women's Health

Michele A. Couri, M.D.
Alexandra Mathern, M.D.
Hope Placher, PA-C
Renee Alwan Percell, PA-C
Deborah Collins, PA-C
Dana Humes Goff, C.N.M., D.N.P.
Lauren Ponder, FNP-C

Gynecological Questionnaire

Date _____

Name _____

Address _____ **Home Telephone** ( ) _____

City _____ **State** _____ **Zip** _____ **Cell Telephone** ( ) _____

Patient employed by _____ **Business Telephone** ( ) _____

Date of Birth _____ **Age** _____ **Partner's Name** _____

Pharmacy _____ **Address** _____

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

Referred by Doctor: _____ **Another Patient** _____ **Self** _____ **PCP** _____

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

_____

II. MEDICAL HISTORY – Please check items applicable to you

Previous GYN Surgeries

❑ Cryocautery ❑ Removal of one or both Ovaries ❑ Removal of Tubal Pregnancy
❑ D & C ❑ Colposcopy ❑ Hysterectomy ❑ Abdominal ❑ Vaginal
❑ Cesarean Section ❑ Laparoscopy ❑ Robotic/Laparoscopic
❑ Removal of Ovarian Cyst ❑ Breast Biopsies ❑ Sling for Urinary Incontinence (TVT)
❑ Infertility Surgery

Other Surgeries & Dates: _____

_____

_____

Medical Allergies: _____

_____

_____

Complications: _____

_____

_____

_____

_____

Currently taking these medications & supplements

(Name / Dosage / How Often): _____

_____

_____

_____

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 ❑ Chlamydia

No.	Year	Months Pregnant	Pregnancies: Type of Delivery (Delivery, Miscarriage or Abortion)	Complications (Miscarriages, etc.)

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

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

❑ Other _____

Date of Last:
Pap Smear _____ Menstrual Period _____ Mammogram _____
DEXA _____ Colonoscopy _____
My height is _____ My usual weight is _____ Do you exercise: ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No If yes, how much? _____ Do you use recreational drugs?
Do you use alcohol? ❑ Yes ❑ No If yes, how much? _____ ❑ Yes ❑ No

V. FAMILY HISTORY — Please check if your children, brothers, sisters, parents or grandparents have had AND list who has had the following:

❑ TB _____	❑ Genetic Disease _____	❑ Stroke _____
❑ Leukemia _____	❑ Blood Disease _____	❑ Colon Cancer _____
❑ Other Cancers _____	❑ Osteoporosis _____	❑ Heart Disease _____
❑ High Blood Pressure _____	❑ Diabetes _____	❑ Endometriosis _____

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

VI. LAST IMMUNIZATION DATES:

Tetanus _____ Flu Shot _____ Pneumonia _____ Shingles _____ HPV _____