



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 _____ 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

- | | | |
|--|---|---|
| <input type="checkbox"/> Cryocautery | <input type="checkbox"/> Removal of one or both Ovaries | <input type="checkbox"/> Removal of Tubal Pregnancy |
| <input type="checkbox"/> D & C | <input type="checkbox"/> Colposcopy | <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Abdominal <input type="checkbox"/> Vaginal |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Robotic/Laparoscopic |
| <input type="checkbox"/> Removal of Ovarian Cyst | <input type="checkbox"/> Breast Biopsies | <input type="checkbox"/> Sling for Urinary Incontinence (TVT) |
| <input type="checkbox"/> 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 Stilbesterol (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
- Migraines
- Daily Headaches
- Thyroid Disease
- Breast Lumps
- Female Organs
- Weight
- Epilepsy
- Breathing
- Other _____
- Hair loss / excess
- Asthma
- Heart Murmur
- Rheumatic Fever
- High Blood Pressure
- Pelvic Infection
- Heart
- Sexual Relationship
- Joints, Muscles, Arthritis
- Sleeping
- Toxemia
- Stomach Ulcer
- Gallstones or Attacks
- Hepatitis
- Urinary Tract Infection
- Depression
- Bladder
- Loss of Urine when coughing or sneezing
- Blood Clots in legs or lungs
- Fractured Pelvic Bones
- Diabetes
- Endometriosis
- Anemia
- Hands, Feet
- Digestion
- Osteoporosis
- Malignancy
- Bowels
- Rectum

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 _____
- Leukemia _____
- Other Cancers _____
- High Blood Pressure _____
- Female Cancer: Cervix _____ Uterus _____ Ovaries _____
 Breast _____ Tubal _____
- Genetic Disease _____
- Blood Disease _____
- Osteoporosis _____
- Diabetes _____
- Stroke _____
- Colon Cancer _____
- Heart Disease _____
- Endometriosis _____

VI. LAST IMMUNIZATION DATES:

Tetanus _____ Flu Shot _____ Pneumonia _____ Shingles _____ HPV _____