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

☐ 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_____

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