COURI CENTER
for Gynecology and Integrative Women's Health

Michele A. Couri, M.D.
Cameron Mouro, M.D.
Renee Alwan Percell, PA-C
Dana Humes Goff, C.N.M., D.N.P.

Hope Placher, PA-C
Deborah Collins, PA-C
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**

Sexual Orientation: ☐ **Straight** ☐ **Lesbian** ☐ **Gay** ☐ **Bisexual** ☐ **Queer** ☐ **Other** _____
☐ **Decline to Answer**

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

Other Surgeries & Dates: _____

_____

_____

Medical Allergies: _____

_____

_____

Complications: _____

_____

_____

_____

_____

Currently taking these medications & supplements

(Name / Dosage / How Often): _____

_____

_____

_____

_____

Sex Assigned at Birth: ☐ **Male** ☐ **Female** ☐ **Intersex** ☐ **Decline to Answer**

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 _____