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**

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 Surgies & 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
- ❑ Migraines
- ❑ Daily Headaches
- ❑ Thyroid Disease
- ❑ Breast Lumps
- ❑ Female Organs
- ❑ Weight
- ❑ Epilepsy
- ❑ Breathing
- ❑ Hair loss / excess
- ❑ Asthma
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ High Blood Prcssure
- ❑ 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
- ❑ 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 ____________