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 _____