Advanced OB-GYN ASSOCIATES

INITIAL WOMEN'S HEALTH ASSESSMENT

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical records and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: _____ DOB: _____ Date: _____
(Last) (First) (Middle Initial)

Please note the reason for your visit today? _____

Who referred you? _____

Primary Care Provider _____ Phone # _____

PCP Address _____

ALLERGIES:

Please note any allergies or reactions to medications or other agents. ☐ None

Medication:_____ Reaction: _____

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Medication:_____ Reaction: _____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: ☐ None

Please include any medications you currently take including DOSAGE and INSTRUCTIONS.

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

GYNECOLOGIC STATUS

Menstrual History: (skip to next section if you are Post-Menopausal)

Date your last period began:_____ Was it normal? ☐ No ☐ yes

How often are your periods? _____ How many days do your periods last? _____

Flow: ☐ heavy ☐ average ☐ light

Do you think you have a problem with your period? ☐ No ☐ Yes

If yes, Explain: _____

Birth Control:

What method of birth control, if any are you using? _____

Are you satisfied with your current method? ☐ Yes ☐ If No, Why _____

Post-Menopausal: (skip if you are pre-menopausal)

Post-Menopausal since age: _____ Have you ever been on Hormone Replacement Therapy? ☐ No ☐ Yes

Why or Why not? _____

If so, for how long? _____ Are you experiencing any vaginal bleeding? ☐ No ☐ Yes

Sexual History:

Are you sexually active? ☐ No ☐ Yes Are your partner(s) ☐ male ☐ female

Do you or your partner have more than one partner? ☐ No ☐ Yes ☐ I don't know

GYNECOLOGIC HISTORY

Have you had any of the following: (please circle all the apply)

Ovarian cyst	Fibroid uterus	Infertility
Polycystic ovaries	Endometriosis	
Abnormal uterine structure	Abnormal pap	

MEDICAL HISTORY

Do you have any major medical problems? ☐ No ☐ Yes: _____

Have you ever had or been diagnosed with: (please circle all the apply)

Cancer	Gall bladder disease	Migraines
Heart murmur	Hepatitis/jaundice	Depression
High blood pressure	Irritable bowel	Alcoholism
High cholesterol	Colitis	Drug addiction
Heart attack or angina	Thyroid Disease	Osteoporosis
Stroke	Diabetes	Arthritis
Phlebitis/blood clots	Anema	Kidney problems
Pulmonary embolus	Sickle Cell Trait	Other _____
Asthma	TB (tuberculosis)	_____
Ulcers	seizures	

Pap Smear History:

Date of last pap smear: _____

Have you had abnormal pap smears? ☐ No ☐ Yes , Date & Result _____

SURGICAL/HOSPITALIZATION HISTORY:

List all hospitalization, operations or major injuries (excluding pregnancy):

DATE	HOSPITALIZATIONS, OPERATIONS, OR MAJOR INJURIES

OBSTETRICAL HISTORY:

Have you ever been pregnant? ☐ No ☐ yes

If yes, how many times have you been pregnant? (including miscarriages and abortions) _____

How many children do you have? _____ **Please list all pregnancies below**

Pregnancy Outcome (Vaginal, C-Section, VBAC, miscarriage, ectopic, induced abortion)	Date (or year if unsure)	How far along were you?	Problems or Complications

Do you smoke cigarettes? ☐ never ☐ formerly ☐ currently