ELITE GYNECOLOGY

Thank you for choosing Elite Gynecology. Please fill out this questionnaire completely as best you can.

Name:_____Date of Birth:_____

Reason for Visit:_____

Primary Care Provider:_____

Menstrual History: (Complete even if you are post-menopausal or no longer having periods)
Age at first period:_____years
First day of your last menstrual period:_____ (MM/DD/YY)
If your menstrual periods are regular; periods start every _____days.
If your menstrual periods are irregular; periods start every _____to_____days.
Duration of bleeding:_____days Heavy flow? [ ] yes [ ] no
Is pain associated with periods? [ ] yes [ ] no [ ] occasionally
If yes, is it before menses?_____during menses?_____both?_____
Does bleeding or spotting occur between periods? [ ] yes [ ] no
Does bleeding or spotting occur after intercourse? [ ] yes [ ] no
Any bleeding/spotting since going through Menopause (if applicable) [ ] yes [ ] no

GYN History:
Date of last pap smear:_____ Any prior abnormal pap smears? [ ] yes [ ] no
Treatment for abnormals: [ ] none [ ] Repeat Pap [ ] Cryotherapy [ ] Laser
[ ] LEEP [ ] Cone Biopsy [ ] Other_____
Have you received the HPV vaccination (Gardasil) [ ] yes [ ] no
Have you been diagnosed/treated for an STI/STD in the past? [ ] yes [ ] no
If yes, which?_____
Date of last mammogram:_____(MM/YY)
Have you had an abnormal mammogram? [ ] yes [ ] no
Have you ever had a breast biopsy? [ ] yes [ ] no
Date of last Bone Density:_____Date of last Colonoscopy:_____

Contraception:
Are you currently sexually active? [ ] yes [ ] no
Which method of contraception are you currently using?_____
What other methods have you used in the past?_____

Method	Brand Name	Date of Usage	Reason for stopping?
Birth Control Pills			
IUD/Implants			
Condoms			
Other			

Obstetrical History:
Total Number of pregnancies: _____ Total of term deliveries:_____
Total # of pre-term deliveries: _____Total # if living children: _____
Total # of induced abortions: _____ Total # of miscarriages: _____

Date	Gender	Weight	Length of Pregnancy	Delivery Type (Vaginal/C/S/Vacuum/Forcep)	Complications

Name:_____Date:_____

Medical History:

Condition	Details/Explanation	Condition	Details/Explanation
[ ] Diabetes		[ ] Chronic headaches/Migraines	
[ ] Kidney Disease		[ ] Mood/Emotional Problems	
[ ] Recurrent UTI's		[ ] Thyroid Problem/Goiter	
[ ] High Blood Pressure		[ ] Asthma/Pnuemonia	
[ ] Liver Disease/Hepatitis		[ ] Glaucoma	
[ ] Heart Problems		[ ] Tuberculosis	
[ ] Blood Disorders/Anemia		[ ] Arthritis/Bone Problems	
[ ] Epilepsy/Seizures		[ ] Nerve Problems	
[ ]Toxin/Radiation Exposure		[ ] Other_____	

Medications: Prescriptions and Over the Counter (OTC). Attach additional sheets as necessary

Name of Medicine	Dosage/Strength	Frequency of Use	Reason or indication

Allergies/Intolerances: Please list any allergies to drugs or substances below

Drug/Substance	Reaction/Severity

Questions about your lifestyle:

Do you use tobacco products? [ ] yes [ ] no Amount used and length of use:_____

Do you drink alcoholic beverages? [ ] yes [ ] no How much?_____How often?_____

Type of alcoholic beverage used?_____

Do you use "recreational drugs"? [ ] yes [ ] no Please describe:_____

Do you exercise regularly? [ ] yes [ ] no How many days per week? _____

Hospitalizations & Surgeries:

Date	Procedure/Reason for Hospitalization	Complications/Findings

Health of Close Relatives: (Parents, siblings, grandparents- include aunts/uncles if significant)

Relationship	Name	Date of Birth/Age	Current Health	Significant Health Problems
Mother				
Father				