SPECIALIST GYNECOLOGIST OBSTETRICIAN

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ALEXANDRA PARK
HARARE, ZIMBABWE

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NAME:

D.O.B

AGE:

CELL

Gynecologic History and Examination Questionnaire

A

1. Marital status: ☐ single ☐ married ☐ long term relationship ☐ divorced ☐ widowed
2. Reason for this visit: _____
3. Referring Physician: _____
4. Occupation: _____
5. Preferred phone number: _____ confidential, voice mails? ☐ Yes ☐ No
6. Partner: _____ ☐ None
7. Age of partner: _____ 8. Occupation of partner: _____

B **Menstrual History** (complete even if post-menopausal or no longer having periods)

9. Age at first period: _____ years.
10. If your menstrual periods are regular, periods start every: _____ days
11. If your menstrual periods are irregular, periods start every: _____to_____ days
12. Duration of bleeding: _____ days
13. Amount of flow ☐ ight ☐ moderate ☐ heavy ☐ with clots?
14. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
15. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
16. First day of Last menstrual period _____/_____/_____
17. Is pain associated with periods? Yes ☐ No ☐ Occasionally ☐
18. Pain on a scale 1 -10 ☐
19. If yes to question 17, is it: before menses? ☐ During menses? ☐ Both ☐
20. Are you in pain passing stool? Y / N
21. Is there blood in the stool during menses? Y / N

C **PREGNANCY HISTORY (All pregnancies)** **Have never been pregnant** ☐

22. Obstetrical History Including abortions & Ectopic (tubal) Pregnancies

Year	Place of delivery or abortion	Duration of Preg.	Hours of labour	Type of delivery	Complications mother & /or infant	Sex	Birthday weight	Present health

D BIRTH CONTROL HISTORY

23. What birth control method(s) do you currently use? _____

24. What method did you use? _____ Duration_____

25. Reason for discontinuation: _____

E SEXUAL HISTORY

26. Do you have a sexual partner? Y / N

27. Are you active? Y / N

28. Are there concerns about your sexual activity which you may want to discuss with your doctor (such as libido or orgasm) ☐ Yes ☐ No

29. Are you in pain during intercourse? _____

30. History of sexual abuse/ assault Y / N

F PAST OBSTETRICAL /GYNECOLOGICAL SURGERIES

31. Check any that apply

SURGERY	YEAR	SURGERY	YEAR
☐ D & C		☐ Ovarian surgery	
☐ Hysteroscopy		☐ L cyst (s) removed ovarian	
☐ Infertility Surgery		☐ R cyst (s) removed ovarian	
☐ Tuboplasty		☐ L ovary removed	
☐ Tubal Ligation		☐ R ovary removed	
☐ Laparoscopy		☐ Vaginal or bladder repair	
☐ Hysterectomy (vaginal)		☐ for prolapsed incontinence	
☐ Hysterectomy (abdominal)		☐ Cesarean section	
☐ Myomectomy			

Other (specify) _____

_____

G PAST SURGICAL HISTORY (Not OB/GYN)

32. List all surgeries and their year ☐ None

SURGERIES	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

H **PAP SMEAR / MAMMOGRAM HISTORY**

33. Date of last pap smear _____/_____/_____

34. Have you ever had abnormal pap smears? No ☐ Yes ☐

35. Have you had treatment for abnormal smears? Y / N YEAR

If yes, what type of treatment have you had? Cryotherapy _____

Laser_____

Cone Biopsy_____

Loop excision_____

36. Date of last mammogram _____ (month) _____ (year)

37. Have you ever had an abnormal mammogram? No ☐ Yes ☐

OTHER PAST GYNECOLOGICAL HISTORY

38. Check any that apply ☐ None ☐ Venereal warts ☐ Herpes-genital ☐ Syphilis

☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea

Vaginal Infections ☐ Other: _____

I **PAST MEDICAL HISTORY** Check any that apply; or None ☐

☐ Arthritis ☐ Kidney Disease ☐ Asthma ☐ Bronchitis ☐ Gallstones ☐ Emphysema ☐ Epilepsy

☐ High Blood Pressure ☐ Eating Disorder ☐ Heart Disease ☐ Thyroid Disease ☐ Depression ☐ Anxiousness ☐ HIV+

☐ Emotional Instability ☐ Diabetes (☐ Diet Controlled ☐ Pill Controlled ☐ Insulin controlled)

☐ Liver Disease (☐ including hepatitis) ☐ Other _____

J **CURRENT MEDICATIONS** (include dose / amount per day)

Medication	Dose	Frequency

K **DO YOU CURRENTLY?**

39. Smoke Y / N _____ packs /day

40. Use Alcohol Y / N --------- wine (glasses / day) ____beer (bottle/ day) _____ hard liquid (oz , day)

41. Use illicit drugs Y / N Type_____ Amount _____

42. Exercise: Type _____ How often _____

L **DRUG ALLERGIES**

43. No ☐ Yes ☐ LIST

_____

_____

_____

M **FAMILY HISTORY**

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Ovarian Cancer ☐ Endometrial Cancer

☐ Colon Cancer ☐ Other _____

If "yes" to any, please list affected relatives

_____ _____

_____ _____

☐ None of the above

N **OTHER SYMPTOMS**

Have you had recent?

☐ Weight loss ☐ Hair growth ☐ change in energy ☐ Weight gain ☐ Change in urinary function

☐ Hair loss ☐ Hot Flushes/ Flushing ☐ Breast Discharge ☐ change in exercise tolerance

☐ Other _____

This is to certify that I read in full and understood all the information contained in this questionnaire

_____ _____ _____

PATIENT SIGNATURE DATE TIME

_____ _____ _____

PHYSICIAN SIGNATURE DATE TIME