

**GENESIS WOMEN'S CENTER PC HEALTH QUESTIONNAIRE Page 1**

Today's Date: _____ Name: _____ Referred by: _____ Primary Care Physician: _____ Reason for Visit: _____	Age: _____ DOB: _____  Pharmacy: _____ Occupation: _____
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**GYN HISTORY**

Last Physical Date: _____	Yes	No	Never																																			
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:15%; text-align: center;">NL</td> <td style="width:15%; text-align: center;">ABN</td> <td style="width:15%; text-align: center;">Date</td> <td style="width:20%;"></td> <td style="width:15%;"></td> <td style="width:15%;"></td> </tr> <tr> <td style="padding: 5px;">Last mammogram</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> <td style="padding: 5px;">H/O abnormal pap</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Last pap</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> <td style="padding: 5px;">Hormones [HRT]</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Bone scan</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">_____</td> <td style="padding: 5px;">H/O STD</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Colonoscopy</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="padding: 5px;">Type: _____</td> <td></td> <td></td> </tr> </table>		NL	ABN	Date				Last mammogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	H/O abnormal pap	<input type="checkbox"/>	<input type="checkbox"/>	Last pap	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hormones [HRT]	<input type="checkbox"/>	<input type="checkbox"/>	Bone scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	H/O STD	<input type="checkbox"/>	<input type="checkbox"/>	Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>		Type: _____					
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**MENSTRUAL HISTORY**

Date of Last Period: _____	<input type="checkbox"/>	Regular	<input type="checkbox"/>	Irregular
Menopausal age: _____	<input type="checkbox"/>	Heavy	<input type="checkbox"/>	Painful
Age 1st Period: _____	<input type="checkbox"/>	Clots	<input type="checkbox"/>	Uses Pads + Tampons ea cycle
No. Days Bleeding: _____	<input type="checkbox"/>	Bleeding between menses	<input type="checkbox"/>	Bleeding after intercourse
	<input type="checkbox"/>	Other		

<b>CURRENT BIRTH CONTROL</b> <span style="float: right;">None <input type="checkbox"/></span>	<b>ALLERGIES</b> <span style="float: right;">None <input type="checkbox"/></span>										
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**GENESIS WOMEN'S CENTER PC HEALTH QUESTIONAIRE Page 2**

<b>PREGNANCY HISTORY</b> <b>None</b> <input type="checkbox"/>									
Mo /Day / Year	Weight	Gestational Age	Sex	Type of Delivery	Place of Delivery	Length of Labor	Anesthesia	Preterm Labor Yes / No	Comments / Any Complications

<b>LIST ALL MEDICATIONS</b> <b>None</b> <input type="checkbox"/>	<b>SOCIAL HISTORY</b> <b>[Circle one]</b>
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Marital Status:      M    S    D    W</p> <p>Smoking:      Y                  N    Quit</p> <p>                    Number packs/day: _____</p> <p>Alcohol:      No      Social      Frequent</p> <p>Other Illicit Drugs: _____</p> <p>Highest Level of Education: _____</p>

<b>PAST MEDICAL HISTORY</b> <b>None</b> <input type="checkbox"/>		
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Endometrial Cancer	<input type="checkbox"/> Sickle Cell Trait [disease]	<input type="checkbox"/> Migraines
<input type="checkbox"/> Ovarian Cyst	<input type="checkbox"/> Leg Clots	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Other	

<b>PAST SURGICAL HISTORY</b> <b>None</b> <input type="checkbox"/>	<b>FAMILY HISTORY</b> <b>None</b> <input type="checkbox"/>
<input type="checkbox"/> C/section x _____ <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Endometrial Ablation <input type="checkbox"/> Other: _____	<p align="right">Whom</p> <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Breast Cancer _____ <input type="checkbox"/> Ovarian Caner _____ <input type="checkbox"/> Down Syndrome _____ <input type="checkbox"/> Other: _____