Phuong T. Nguyen, MD, FACOG
Obstetrics & Gynecology

Name: _____
Date of Birth:_____
Date:_____

GYNECOLOGY HEALTH QUESTIONNAIRE

Name of your family doctor: _____

Briefly describe what you want to discuss with your provider today:

_____

Personal Health History

Number of pregnancies: _____ Number of live births: ____ Vaginal deliveries: _____
Cesarean: _____ Miscarriages: _____ Abortions: _____ Ectopic: _____

First day of last menstruation: ___/___/___ Age at first menstruation: _____

Period every ____ days Period lasts ____ days.

Date of last Pap smear: ___/___/___ Prior treatment of abnormal Pap smears? □ Yes □ No

Date of last Mammogram: ___/___/___ Date of last colonoscopy: ___/___/___

Are you sexually active (within the past 6months)? □ Yes □ No

Current birth control method: _____

Previous birth control methods: _____

History of sexually transmitted disease? □ Yes □ No. If yes, please list type: _____

Number of lifetime sexual partner(s): _____

List any medical problems you have or have had (please add information below if need):

Year	Diagnosis

List any prior surgeries you have had (please add information below if need):

Year	Procedure	Hospital or Doctor

List any allergies to medications, food or latex (please add information below if need):

Name of drug	Reaction you had

Please continue on the other side →

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List any prescription medications, vitamins, herbal products, and over the counter drugs:

Drug	Strength	Frequency of dose

Health habits and personal safety

Describe your exercise habits (how often?): _____

Do you follow a special diet? □ Yes □ No. Describe: _____

Do you smoke? □ Yes □ No. If yes, how many/day?_____ How many years? _____

Do you drink alcohol? □ Yes □ No. If yes, how many drinks/day? _____ Per week? _____

Do you use or have you used recreational or street drugs? □ Yes □ No.

Do you feel safe at home? □ Yes □ No.

Would you like to discuss anything related to sexuality? □ Yes □ No.

Would you like to discuss anything related to domestic/sexual abuse? □ Yes □ No.

Marital status: □ single □ partner □ married □ separated □ divorced □ widow

What is your occupation? _____

Family health history
Has anyone in your family had:
Ovarian cancer? □ No □ Yes (relationship to you/age at diagnosis) _____
Breast cancer? □ No □ Yes (relationship to you/age at diagnosis) _____
Colon cancer? □ No □ Yes (relationship to you/age at diagnosis) _____
Diabetes? □ No □ Yes (relationship to you/age at diagnosis) _____
Heart attack before age 55? □ No □ Yes (relationship to you) _____
Stroke before age 55? □ No □ Yes (relationship to you) _____

REVIEW OF SYSTEMS
Please circle any problems you have in the following areas:
General: Unexplained weight loss hot flashes night sweats
Ears/Nose/Throat: Cough seasonal allergies hearing deficit
Lungs: Asthma shortness of breath
Heart: Palpitation pain or pressure
Back: pain weakness
Bowels: constipation diarrhea pain gas bloating blood in stools
Bladder: frequent infections blood in urine painful urination incontinence
Endocrine: diabetes low blood sugar thyroid heat or cold intolerance
Sexual function: pain with intercourse lack of desire
Psychiatric: anxiety mood swings pain attacks insomnia