

NAME: _____ Reviewed _____ Pt initials _____ MD/NP _____

Date: ____/____/____ Reviewed _____ Pt initials _____ MD/NP _____

Referred by: _____ Reviewed _____ Pt initials _____ MD/NP _____

Number of pregnancies: _____ Number of children: _____ Date of birth ____/____/____

GYN HISTORY	YES	NO	
Are your periods regular, once a month?	<input type="checkbox"/>	<input type="checkbox"/>	Are you in a single partner relationship? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you have cramps with your periods?	<input type="checkbox"/>	<input type="checkbox"/>	Current contraception? <input type="checkbox"/> none
Any bleeding between your periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> condoms <input type="checkbox"/> pills <input type="checkbox"/> depo provera shot
Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> patch <input type="checkbox"/> IUD <input type="checkbox"/> vaginal ring <input type="checkbox"/> diaphragm
Are you currently sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> tubal ligation <input type="checkbox"/> vasectomy <input type="checkbox"/> rhythm method
If so, is partner <input type="checkbox"/> male <input type="checkbox"/> female			Any history of: <input type="checkbox"/> ovarian cyst
Duration _____ months or _____ years			<input type="checkbox"/> fibroids
			<input type="checkbox"/> breast lump/breast disease

<i>Please check if you have ever been treated for any of the following infections:</i>	YES	NO
Vaginal bacterial infection/BV/Vaginosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trichomonas <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Warts <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had an abnormal pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
When? _____ (w/in 3 years=HR)		
Has it been more than 7 years since your last pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
Did you begin sexual activity before you were 16 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had more than 5 sexual partners in your lifetime?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with HIV?	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take the drug DES while pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL PROBLEMS	YES	NO	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma/chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney infection/stones	<input type="checkbox"/>	<input type="checkbox"/>	
Heart trouble/murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	type _____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL PROBLEMS	YES	NO
Blood clots in veins/arteries	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

OPERATIONS	YES	NO	DATE
C-section	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	DATE
Gall bladder removed	<input type="checkbox"/>	<input type="checkbox"/>	
Breast biopsy	<input type="checkbox"/>	<input type="checkbox"/>	
Other surgery/hospitalization:			_____

FAMILY HISTORY	YES	NO	WHO?
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	WHO?
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack/stroke before age 50	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clot requiring blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____			

MEDICATIONS: <input type="checkbox"/> none	ALLERGIES: <input type="checkbox"/> none
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SOCIAL HISTORY	YES	NO
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol at all?	<input type="checkbox"/>	<input type="checkbox"/>
Avg. # drinks/day _____		
Do you use any recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you eat a diet high in fat/sugar?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a seat belt?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel safe in your home/relationship?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYSTEMS: *Please check if any of the following apply:*

	<i>Today's Date:</i>	<i>Date:</i>	<i>Date:</i>	<i>Date:</i>
1. CONSTITUTIONAL	Weight loss/gain (unexpl.) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Headaches <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fever <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Fatigue <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. EYES	Spots before eyes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vision changes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. ENT/MOUTH	Ear problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ringing in ears <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sinus problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CARDIOVASCULAR	Chest pain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart racing/skipping beats <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. RESPIRATORY	Wheezing <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. GASTROINTESTINAL	Diarrhea or constipation <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Blood in stool <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nausea/vomiting <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. GENITOURINARY	Pain with urination <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Frequency/urgency of urination <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Leaking urine <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heavy periods <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Irregular periods <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bleeding between periods <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pelvic pain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pain with intercourse <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vaginal itching/burning <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal discharge <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL	Muscle weakness <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle/joint pain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. SKIN/BREAST	Pain in breast <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lump in breast <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nipple discharge <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rash <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ulcers/sores <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. NEUROLOGICAL	Dizziness <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Numbness in arms/legs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. PSYCHIATRIC	Depression or anxiety <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. ENDOCRINE	Heat/cold intolerance <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Abnormal thirst <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hot flashes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. HEMATOLOGIC/ LYMPH	Frequent bruises <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cuts that do not stop bleeding <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Enlarged lymph nodes/glands <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. ALLERG/IMMUNOL.	Allergies (food/pollen/etc) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Last period: <input type="checkbox"/> Never	____/____/____	____/____/____	____/____/____	____/____/____
Last pap smear: <input type="checkbox"/> Never	____/____/____	____/____/____	____/____/____	____/____/____
Last mammogram: <input type="checkbox"/> Never	____/____/____	____/____/____	____/____/____	____/____/____
Last bone density test: <input type="checkbox"/> Never	____/____/____	____/____/____	____/____/____	____/____/____
Last colonoscopy: <input type="checkbox"/> Never	____/____/____	____/____/____	____/____/____	____/____/____

Patient signature _____

Date _____

Physician/NP signature _____

Date _____

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Purple Book/Gyn Questionnaire

Rev: 03-16-07