KENNESAW GYNECOLOGY

PATIENT NAME: _____ ***DOB:*** _____ ***Date:*** _____

Please answer ALL questions prior to arriving to your scheduled appointment time. Failure to complete all of your questionnaires will delay your visit with the provider.

Gyn History

Date of Last Period (MM-DD-YYYY)

Do you experience abnormal menstruations?

☐ Yes ☐ No

Which imaging center would you like your mammograms, bone density, or any other imaging orders sent?

When was your last pelvic ultrasound?

Have you ever had a Colposcopy? If yes, please list the date.

What age did Menopause begin?

Have you had a hysterectomy?

☐ Yes ☐ No

Last Pap Smear Date: (MM-DD-YYYY)

Have you been tested for Human Papillomavirus (HPV)? If so, what was your result?

☐ Negative ☐ Positive: Negative for 16/18/45 ☐ Positive ☐ Never been tested

Have you ever had an abnormal pap smear result?

☐ Yes ☐ No

Last Mammogram Date?

Date of Last Colonoscopy?

Date of Last Bone Density?

Age at first intercourse

Patient Initials _____

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What is your current birth control method?

☐ Abstinence ☐ Birth Control Pills ☐ Condoms ☐ Diaphragm ☐ Depo ☐ Hysterectomy ☐ Kyleena ☐ Mirena ☐ Menopause ☐ Nexplanon ☐ None ☐ Nuvaring ☐ Paragard ☐ Tubal Ligation ☐ Spermicide ☐ Vasectomy ☐ Withdrawal

Are you sexually active?

☐ Yes ☐ No

What is your sexual orientation?

☐ Bisexual ☐ Heterosexual ☐ Homosexual ☐ Transgender

Do you have any history of Sexually Transmitted Diseases (STDs)?

☐ No history ☐ Humana Papilloma Virus (HPV) ☐ Herpes Simplex Virus (HSV) ☐ Chlamydia ☐ Gonorrhea ☐ Human Immunodeficiency Virus (HIV) ☐ Trichomoniasis (Trich)

Do you have history of Cervical Dysplasia?

☐ Yes ☐ No

Do you have history of Endometriosis?

☐ Yes ☐ No

Do you have history of Fibroids?

☐ Yes ☐ No

Do you have history of PCOS?

☐ Yes ☐ No

Do you have history of Recurrent Ovarian Cysts?

☐ Yes ☐ No

Do you have history of Infertility?

☐ Yes ☐ No

HPV Vaccine?

☐ Completed ☐ Not Completed ☐ Not Applicable

What age did you first start your period?

Periods:

☐ Every 28 days ☐ Every Month ☐ Every 20-25 days ☐ Every 30-40 days ☐ Every 3 months ☐ Irregular ☐ Never

Patient Initials _____

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OB History

How many total pregnancies have you had?

Of those pregnancies, please indicate how many of the following:

Abortion(s)?

C-Section(s)?

Miscarriage(s)?

NVD- Normal Vaginal Delivery

Total Living Children

Past Medical History (Please only select YES if you have been diagnosed by a health care provider)

- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer, breast
- ☐ Cancer, Cervical
- ☐ Cancer, Colon
- ☐ Cancer, Ovarian
- ☐ Cancer, Skin
- ☐ Cancer, Thyroid
- ☐ Cancer, Uterus
- ☐ Deep Vein Thrombosis
- ☐ Colon Polyps
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Recurrent Urinary Tract Infections
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Urinary Incontinence
- ☐ Uterine Fibroids
- ☐ Uterine Prolapse
- ☐ Von Willebrands Disease
- ☐ Thyroid Nodule

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Family History

Please be sure to indicate any cancers, high blood pressure, high cholesterol, heart disease, or disorder of thyroid if applicable for ANY BLOOD relative. Also, include the age that your relative was diagnosed. Please do NOT include their names.

☐ I am adopted and do not know my biological family history

Please list any Medical History that your MOTHER was diagnosed with.

Please list any Medical History that your MATERNAL GRANDMOTHER was diagnosed with.

Please list any Medical History that your MATERNAL GRANDFATHER was diagnosed with.

Please list any Medical History that your MATERNAL AUNT was diagnosed with.

Please list any Medical History that your MATERNAL UNCLE was diagnosed with.

Please list any Medical History that your FATHER was diagnosed with.

Please list any Medical History that your PATERNAL GRANDMOTHER was diagnosed with.

Please list any Medical History that your PATERNAL GRANDFATHER was diagnosed with.

Please list any Medical History that your PATERNAL AUNT was diagnosed with.

Patient Initials _____

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Please list any Medical History that your PATERNAL UNCLE was diagnosed with.

Please list any Medical History that your DAUGHTER(s) was diagnosed with.

Please list any Medical History that your SON(s) was diagnosed with.

Social History

Martial Status

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Not Answered

Are you smoker?

☐ Nonsmoker ☐ Current Smoker ☐Former Smoker

Do you drink alcohol?

☐ No ☐ Daily ☐ Socially ☐ Occasional ☐ Moderate

Domestic Violence?

☐ Yes ☐ No

Do you have a history of sexual abuse?

☐ None ☐ Has Safety Plan ☐ History in the Past ☐ Ongoing in Relationship

Country of Birth:

Level of Education:

☐ Not Finished High School ☐ Finished High School ☐ Not Finished College ☐ Finished College

☐ Professional Schools/Masters/PhD ☐ Not Answered

Occupation:

Do you exercise? If so, how often?

☐ Daily ☐ 1-2 times a week ☐ 3-4 times a week ☐ None

Religion:

Hobbies:

Traveled Outside the United States in the last 6 weeks?

☐ Yes ☐ No