advocare | Premier Ob/Gyn of South Jersey

Patient History Questionnaire

Today's Date:_____/_____/__________ **Are you currently pregnant?** _________________

Your Name ____ Date of Birth _____/_____/__________

Who referred you to this practice? ____

May we send a "Thank You" letter to that person? ____

When was your last gynecologic exam and PAP? _______________ by Dr. ______________________________

Who is your family or primary care doctor? ____

Please list any medical problems you have had in the past (i.e. heart disease, high blood pressure, asthma, etc)

____
____
____
____
____

Please list any surgeries, hospitalizations or serious accidents that you have had (including minor surgeries such as tonsils, wisdom teeth, appendix, etc)

Year Surgery

____
____
____
____
____

Please list any pregnancies you have had, including details as best as you can recall:

Year	Sex	#Weeks	Baby Weight	Type of Delivery	Anesthesia	Any problems with the pregnancy?

Have you ever had a miscarriage? __________ How many? __________
Have you ever had an abortion? __________ How many? __________

Have you ever had any of the following sexually transmitted diseases:

______ Herpes ______ Human Papilloma Virus _____Gonorrhea ______ Chlamydia

_____ Abnormal PAP ______ other ______ I will discuss at my appointment

Have you ever been sexually assaulted? __________

Age when you had your first period: __________ Frequency of menses: every ______ days, or IRREGULAR?

How many days of heavy bleeding? __________ Are your periods particularly painful? __________

Have you ever taken birth control pills? __________ What kind(s) ____________________________________

Are you sexually active? _________ How many current partners? __________

Are you involved in a lesbian or bisexual relationship? _____________________

Have you ever taken hormone replacement therapy for menopause? __________

Please list all medications, include doses:

____

____

____

____

Do you have any **ALLERGIES** to medications or foods? ____

____

Do you smoke? __________ How much? _______________________________

Do you consume alcohol? __________ How much? _______________________

Do you engage in illegal drug use? _____________________________________

Are you: SINGLE MARRIED DIVORCED WIDOWED Spouse's name (if married) _______________

What is your occupation? ____

Do you have any pets at home? ______________________________________

Have you been a victim of domestic violence? ____________________________

Do you exercise? ___________

What is your family background? (i.e. before they came to America) __________________________________

What is the family background of your spouse? ____

Please list any cancers in your family:

<u>Relative</u> <u>Cancer Type</u>

____
____
____
____

Please list any family history of medical diseases (such as diabetes, heart disease, hypertension, stroke, etc)

<u>Relative</u> <u>Medical Problem</u>

____
____
____
____

Do you have any family history of birth defects, mental retardation, or babies that died at birth?

____
____

Does your spouse have any family history of birth defects, mental retardation or babies that died at birth?

____
____

Do you <u>currently</u> have any of the following symptoms:

____ Fever/Chills	____ Diarrhea/Constipation	____ Bloody Urine
____ Weight gain/loss	____ Hemorrhoids	____ Painful Urination
____ Headaches	____ other GI symptoms	____ Urinary Incontinence
____ Anxiety/Depression	____ Chest pain	____ Breast pain/Breast lump
____ Too hot/too cold	____ Shortness of breath	____ Nipple discharge
____ Menopause symptoms	____ Bruise/Bleed easily	____ Painful Intercourse
____ muscle/joint pain	____ Bleeding gums	____ Vaginal discharge
____ Bloating/gas	____ Vision disturbances	____ Vaginal or skin lesions

Is there anything that we did not ask that you would like us to know, so that we can provide you with optimal gynecological care? ____
____
____
____
____

Advocare Premier OB/GYN of South Jersey
903 Sheppard Road • Voorhees, NJ 08043
856.772.2300 • Advocarepremierobgyn.com