Atrius Health
Part of Optum®

GYNECOLOGY CONSULTATION IN OBGYN

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical record and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: _____ Date:_____
(last) (first) (middle initial)
Please note the reason for your visit today_____

Who referred you?_____

ALLERGIES:

Please note any allergies or reactions to medications or other agents. **None**
Medication: _____ Reaction:_____
Medication: _____ Reaction:_____

CURRENT PRESCRIPTION MEDICATIONS:

Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS. **None**
Med/Dose/Instr: _____
Med/Dose/Instr: _____
Med/Dose/Instr: _____
Med/Dose/Instr: _____
Please list any non-prescription medications, supplements and/or herbal remedies you take: _____

GYNECOLOGIC STATUS

Menstrual History: (skip to next section if you are Post-Menopausal)
Date your last period began: Was it normal? □ no □ yes
How often are your periods? How many days do your periods last?
Flow: □ heavy □ average □ light
Do you think you have a problem with your period? □ no □ yes-Explain:
Post-Menopausal: (skip if your are pre-menopausal)
Post Menopausal since age: Have you ever been on Hormone Replacement Therapy? □ no □ yes
Why or why not? If so for how long?
Are you experiencing any vaginal bleeding? □ no □ yes

Sexual History:

Have you ever had sex or been sexually active? □ no□ yes If yes, are you currently sexually active? □ no□ yes
Do your partner(s) have a □ penis □ vagina (check all that apply)
Have you or your partner(s) had new sexual partner(s) since your last STI test? □ no □ yes
Do you have concerns about sexually transmitted infections (STI)? □ no □ yes □ unsure
Do you have any concerns about sex or your sexual health? □ no □ yes
Do you have any concerns about vaginal dryness or pain with intercourse? □ no □ yes
Do you have any concerns about libido? □ no □ yes
Are you planning a pregnancy ?v□ no □ yes
If at risk for unplanned pregnancy, what method of birth control are you using? _____

OBSTETRICAL HISTORY

How many times have you been pregnant? _____ #children do you have? # delivered vaginally?_____

MEDICAL & GYNECOLOGIC HISTORY: Have you ever been diagnosed with any of the following **0 None**

- ☐ Abnormal Cervical Pap
- ☐ Absent Periods (amenorrhea)
- ☐ Anemia
  - ☐ Sickle Cell ☐ Thalassemia ☐ Arthritis
- ☐ Asthma
- ☐ Cancer: _____
- ☐ Cerebrovascular disease (stroke/TIA)
- ☐ Chickenpox
- ☐ CAD/Heart Attack/Angina
- ☐ Bleeding tendency (coagulation defect)
- ☐ Depression
- ☐ DES Exposure in Utero (when your mother was pregnant with you)
- ☐ Diabetes
  - ☐ Only In pregnancy
- ☐ Painful periods (dysmenorrhea)
- ☐ Pain with sex (dyspareunia)
- ☐ Endocrine
  - ☐ Thyroid
  - ☐ Polycystic ovaries
- ☐ Endometriosis or Adenomyosis
- ☐ Fibroids, uterine
- ☐ Gastrointestinal Problem(s)
  - ☐ GERD
  - ☐ Gallbladder disease
- ☐ Headache (migraine)
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ HIV/AIDS
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Infertility
- ☐ Inflammatory Bowel Disease
  - ☐ Crohns
  - ☐ Ulcerative Colitis
- ☐ Interstitial Cystitis
- ☐ Irritable Bowel
- ☐ Kidney problems
- ☐ Menstrual Disorders
  - ☐ Irregular or infrequent periods
  - ☐ Frequent or heavy periods
  - ☐ Bleeding between periods
- ☐ Osteoporosis
- ☐ Ovarian Cyst, type:_____
- ☐ Pelvic Pain, chronic
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Seizure Disorder
- ☐ STI/Sexually Transmitted Infections
  - ☐ Genital Herpes
  - ☐ Gonorrhea
  - ☐ Genital Warts
  - ☐ Chlamydia
  - ☐ Syphilis
- ☐ Substance abuse
  - ☐ Alcohol
  - ☐ Drugs
- ☐ Tuberculosis
- ☐ Thromboembolic disorder (blood clots in legs or lungs or a tendency to form clots)
- ☐ Urinary Tract Infection (UTI)
- ☐ Uterine Anomaly (abnormal uterine structure)
- ☐ Urinary Incontinence
- ☐ Vaginal dysplasia (precancer)
- ☐ Vulvar dysplasia (precancer)
- ☐ Vulvodynia
- ☐ Vulvovaginitis
  - ☐ Yeast
  - ☐ BV
  - ☐ Other_____
- ☐ Other:

SURGICAL/HOSPITALIZATION HISTORY

List all hospitalization, operations or major injuries (excluding pregnancy):

DATE	HOSPITALIZATIONS, OPERATIONS, OR MAJOR INJURIES

Do you smoke cigarettes? ☐ never ☐ formerly ☐ currently If currently, Amount/PPD

Primary Care Provider_____

PCP's Address (if not Atrius)_____

PCP Phone # (if not Atrius) _____