



Part of Optum®

INITIAL HEALTH ASSESSMENT - OBSTETRICS & GYNECOLOGY DEPARTMENT

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: _____ Preferred Name: _____
(Last) (First) (Middle Initial)

Today's Date: _____ DOB: _____ Marital Status: _____ Occupation: _____

What would you like to address in today's visit? _____

LIFESTYLE/RISK ASSESSMENT:

SMOKING, ALCOHOL, DRUGS, ABUSE

Do you currently smoke cigarettes? no, never have exposure to second hand smoke

yes Date Started: _____ Amt/PPD: _____ quit Date Stopped: _____

How many alcoholic drinks do you have in an average week? none # _____

Do you ever drink more than 3 at one sitting? no yes _____ Have you ever used IV drugs? no yes

What recreational drugs have you used? none marijuana heroin crack cocaine painkillers other _____

Have you ever been physically or emotionally abused? no yes

Do you have a history of alcohol or drug addiction? no yes

EXERCISE & DIET

Do you exercise and if so, how often? regularly occasionally rarely never

What type of exercise: _____

Do you have any concerns about your weight? none gain loss

Do you have any concerns about what you eat: no yes

How many different types of fruits and vegetables do you have in your house right now: 0-3 _____ 4-8 _____ 9 or more _____

Do you regularly have dairy in your diet (yogurt, cheese, milk, etc) no yes

SEXUAL HISTORY

Have you ever had sex or been sexually active? no yes If yes, are you currently having sex? no yes

Do your partner(s) have a penis vagina (check all that apply)

Have you or your partner(s) had new sexual partners since your last STD/STI test? no yes

Do you have concerns about sexually transmitted infections? 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? now in future never unsure

If at risk for unplanned pregnancy, what method of birth control are you using? _____

SAFETY

Do you use sunscreen regularly? no yes

Do you use a seatbelt? no yes

Have you recently felt down, hopeless or had little interest in doing things you used to enjoy? no yes

Have you been emotionally or physically abused by your partner or someone close to you? no yes

Have you ever experienced unwanted sexual touching and/or contact? no yes

Is there anything in your past that might make your visits with us scary, uncomfortable or traumatic? no yes

How would you describe your relationship with your partner? a lot of tension some tension no tension N/A

Do you and your partner work out arguments with great difficulty some difficulty no difficulty N/A

ALLERGIES:**Please note any allergies/ reactions to medications or other agents.** **None**

Allergen and reaction:

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: **None** *Use back for more; If you would like a list of current medications in your medical record, please ask Medical Assistant to provide.*

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

IMMUNIZATIONS:Have you obtained a Tdap immunization (tetanus, diphtheria, pertussis)? **no** **yes** **don't know**Have you been vaccinated against the HPV virus? **no** **yes** **don't know**Have you had a flu shot this season? **no** **yes** **don't know****OBSTETRICAL HISTORY:**Have you ever been pregnant? **no** **yes** If yes, how many times have you been pregnant? _____What age where you: 1st pregnancy _____ 1st live birth _____ How many total months have you breastfed? _____How many children do you have? _____ **Please list all pregnancies (including miscarriages and abortions):**

Pregnancy Outcome (vaginal del, C-section, VBAC, miscarriage, ectopic, induced abortion)	Date (or Year if unsure)	How far along were you?	Problems or Complications

MENSTRUAL HISTORY and STATUS:

At what age did your periods start? _____ If post-menopausal at

what age did your periods stop? _____ **If pre-menopausal:** Date of Last
Menstrual Period: _____In the past were your periods mostly regular mostly irregular, when not
on the birth control pill

Do you have any concerns about your menstrual cycle: _____

Are your periods currently: Regular IrregularIs your Flow: light moderate heavy

How often do you have periods: _____

How many days do your periods last? _____

Do you have spotting or bleeding between periods? no yesDo you have menstrual pain/cramping? no mild moderate severe

What medications do you take for this? _____

If post-menopausal:Are you experiencing any vaginal
bleeding? no yes

Did you use hormones?

 no yes

If yes:

Oral/Patch current pastVaginal current past

GYNECOLOGIC HISTORY

Check if you have had any of the following:

None

- Abnormal Pap Test
- Breast Biopsy
- DES Exposure in Utero (when your mother was pregnant with you)
- Pain with sex (dyspareunia)
- Endometriosis or Adenomyosis
- Fibroids, uterine
- Infertility
- Ovarian Cyst, Type: _____
- Chronic Pelvic Pain
- Pelvic Inflammatory Disease (PID)
- PMS
- STI/Sexually Transmitted Infections
 - Chlamydia
 - Genital Herpes
 - Gonorrhea
 - Genital Warts
 - Hepatitis B
 - Hepatitis C
 - HIV/AIDS
 - Syphilis
- Abnormal Uterine Structure (Uterine Anomaly)
- Urinary Incontinence
- Vaginal dysplasia (precancer)
- Vulvar dysplasia (precancer)
- Vulvar Pain/Vulvodynia
- Recurrent Vaginitis
- Yeast
- BV
- Other _____

MEDICAL HISTORY:

Check if you have ever had or been diagnosed with: **None**

- Anemia
 - Sickle Cell
 - Thalassemia
- Arthritis
- Asthma
- Cancer: _____
- Cerebrovascular disease (stroke/TIA)
- Chickenpox
- CAD/Heart Attack/Angina
- Bleeding tendency (coagulation defect)
- Depression
- Diabetes
 - Only In pregnancy
- Endocrine Problem
 - Thyroid
 - Polycystic ovaries
 - Other
- Gastrointestinal Problem(s)
 - GERD
 - Other
- Gallbladder disease
- Headache (migraine)
- Heart Murmur
- Hepatitis/Jaundice
- HIV/AIDS
- Hyperlipidemia (high cholesterol)
- High blood pressure
- Inflammatory Bowel Disease
- Crohns
- Ulcerative Colitis
- Interstitial Cystitis
- Irritable Bowel
- Kidney problems
- Osteoporosis
- Seizure Disorder
- Substance abuse
 - Alcohol
 - Drugs
- Tuberculosis
- Thromboembolic disorder (blood clots in legs or lungs or a tendency to form clots)
- Urinary Tract Infection (UTI)
- Other: _____

SURGICAL HISTORY:

List all operations (excluding pregnancy): **None**

DATE	SURGERY

Have you had any problems with anesthesia? no yes: _____

FAMILY HISTORY: **Adopted**

Illness	Relation to you	Note if relation is Paternal=P <i>your father's side</i> or Maternal= M <i>your mother's side</i>	Details/Comments
Autoimmune Disease (e.g., <i>lupus, ulcerative colitis, rheumatoid arthritis</i>)			
CAD/Coronary Artery Disease (e.g., <i>Heart Disease/Heart Attack, High Blood Pressure, High Cholesterol</i>)			
Cancer - Melanoma			
Cancer – Endometrial/Uterine			
Cancer - Breast			
Cancer - Colon			
Cancer - Ovarian			
Diabetes			
Genetic Disorders (e.g., <i>Muscular Dystrophy, Tay Sachs, Fragile X Thalassemia, sickle cell</i>)			
Gynecologic Problem (e.g., <i>fibroids, infertility, early menopause, endometriosis</i>)			
Hypercoagulation Disorder (<i>blood clots in legs or lungs</i>)			
Mental Health Concerns (e.g., <i>anxiety, depression, bipolar disorder, etc.</i>)			
Osteoporosis or Hip Fracture			
Stroke			
Thyroid Disease			
Substance Abuse			
Other			

REVIEW OF SYSTEMS: Check if you *currently* have **problems** with:

<input type="checkbox"/> fatigue	<input type="checkbox"/> persistent cough	<input type="checkbox"/> fainting
<input type="checkbox"/> weight loss	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> dizziness/balance
<input type="checkbox"/> weight gain	<input type="checkbox"/> wheezing	<input type="checkbox"/> anxiety
<input type="checkbox"/> easy bruising	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> depression
<input type="checkbox"/> enlarged glands or lumps	<input type="checkbox"/> indigestion or nausea	<input type="checkbox"/> memory loss
<input type="checkbox"/> environmental allergies	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> trouble sleeping
<input type="checkbox"/> hot flashes	<input type="checkbox"/> abdominal bloating	<input type="checkbox"/> varicose veins
<input type="checkbox"/> heat or cold intolerance	<input type="checkbox"/> constipation	<input type="checkbox"/> muscle or joint pain
<input type="checkbox"/> excess hair growth	<input type="checkbox"/> diarrhea	<input type="checkbox"/> back pain
<input type="checkbox"/> excessive hair loss	<input type="checkbox"/> painful urination	<input type="checkbox"/> breast pain
<input type="checkbox"/> skin rash	<input type="checkbox"/> involuntary loss of urine	<input type="checkbox"/> breast discharge
<input type="checkbox"/> changing moles	<input type="checkbox"/> abnormal vaginal discharge	<input type="checkbox"/> breast lump
<input type="checkbox"/> chest pain	<input type="checkbox"/> headaches	<input type="checkbox"/> Other _____

Please note any particular stresses in your life or anything else you think we should know:

Signature: _____ Date: _____

If your Primary Care Physician (PCP) is not an Atrius physician please tell us:

PCP Name, Address: _____

I do not have a PCP

Who Referred You:

PCP

Other, Name and Address: _____

Do you want a copy of today's visit to be sent to your:

	YES	NO	N/A
PCP	<input type="checkbox"/>	<input type="checkbox"/>	
Referring Clinician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Revised: 1/28/26