

# Personal / Family History

Please answer every question.

## Marking Instructions

- Use only the pencil provided.
- Mark all items that apply to you.
- Fill in the complete oval as shown . . .

### Incorrect Marks



PLEASE PRINT YOUR LAST NAME

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PLEASE PRINT YOUR FIRST NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PLEASE PRINT YOUR DATE OF BIRTH

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Month Day Year

## HISTORY OF PRESENT ILLNESS

Person completing form: patient  mother  father   
 grandmother  friend  other

Referred by: self  relative/friend  primary care physician   
 other

Reason for visit: annual  GYN problem  infertility consultation   
 new OB  follow up

Patient status: new  established

## SOCIAL HISTORY

### Tobacco Use

How would you describe your cigarette smoking? current  previous  never

If your answer is "Current" or "Previous", please fill in the year you started smoking: Choose Year 19  20

If your answer is "Previous", please fill in the year you quit smoking: Choose Year 19  20

Cigarettes a day that you smoke (or did smoke):

Passive (second hand) smoke exposure? yes  no

### Alcohol Use

What type(s) of alcohol do you drink? beer  wine  liquor  other

How often do you drink? (Number of times...) never  1  2  3   
 4  5  6  7+

(Per ...) week  month  year  never

How many drinks do you have per occasion? 1-2  3-5  6-9  10+

How often do you have more than five drinks per occasion? never  rarely  occasionally  frequently

### Drug Use

prefer to discuss with health care provider  current  previous  none   
 marijuana  PCP  illicit Rx  cocaine  heroin   
 speed  LSD  crack  meth

### Risk Factors

Please answer yes or no if you have any of the following:  
 IV drug use, multiple blood transfusions, a partner with HIV/Hepatitis B or a partner with any of the aforementioned behaviors. yes  no

### Habits

Caffeine - type(s) of caffeine: coffee  tea  soft drinks   
 - drinks per day: occasionally  0  1-2  3-5  6-9  10+

Exercise - type(s) of exercise: bicycling  running  swimming   
 walking  aerobics  other   
 - times per week: occasionally  0  1-2  3-4  5-6  7+

Seat belt use (% of time used): 0  25  50  75  100

Sun exposure: rarely  occasionally  frequently

### Domestic Violence

Do you feel safe at home? yes  no

Are you currently being hit, punched, kicked, or slapped by anyone? yes  no

Do you need to discuss violence at home with your health care provider? yes  no



### **SURGICAL HISTORY (cont.)**

Please indicate if you have had any of the following:

Breast Biopsy or Lumpectomy

Mastectomy

Cosmetic Surgery

Tubal Ligation

Gall Bladder removed

Tonsillectomy

Appendectomy

Other Surgeries

Please indicate other surgeries:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **GYNECOLOGICAL HISTORY**

**Menstrual period:**

light to moderate flow

excessive flow

excessive cramping

**Length of flow:**

0-4 days

5-7 days

8 or over

**Cycle regularity:**

regular

irregular

don't have periods

*(from 1st day of period to start of next period)*

**Last pap smear:**

none

less than 1 year

1-5 years

more than 5 years

**Have you had an abnormal pap in the past 5 years?**

yes

no

**Have you had Cervical Dysplasia in the past 5 years?**

yes

no

**Last mammogram:**

none

less than 1 year

1-5 years

more than 5 years

**Current contraception:**

*(Mark all that apply.)*

pill/patch/ring

IUD

foam

tubal sterilization/hysterectomy

condom

rhythm

Depo-Provera

abstinence

vasectomy

n/a

none

**Prior contraception:**

*(Mark all that apply.)*

pill/patch/ring

IUD

foam

tubal sterilization/hysterectomy

condom

rhythm

Depo-Provera

abstinence

vasectomy

n/a

none

**Have you ever had a sexually transmitted disease?**

yes

no

**If yes, which types:**

*(Mark all that apply.)*

gonorrhea

syphilis

herpes

chlamydia

HPV

genital warts

other

## SEXUAL HISTORY

- yes  no Have you ever had sex?
- yes  no Are you currently sexually active?
- yes  no Any problems with sexual functions?
- If yes, please explain:
- yes  no Do you have questions regarding sexuality?
- yes  no If you have had sex, did you begin having sex before the age of 18?
- yes  no Have you had greater than 5 partners in your lifetime?

## OBSTETRICAL HISTORY

- 0  1  2  3  4  
 5  more than 5 Number of TOTAL pregnancies:  
(including current pregnancy)
- 0  1  2  3  4  
 5  more than 5 Number of vaginal deliveries (after 20 weeks):
- 0  1  2  3  4  
 5  more than 5 Number of preemies (less than 36 weeks):
- 0  1  2  3  4  
 5  more than 5 Number of stillbirths:
- 0  1  2  3  4  
 5  more than 5 Number of miscarriages:
- 0  1  2  3  4  
 5  more than 5 Number of elective abortions:
- 0  1  2  3  4  
 5  more than 5 Number of ectopic pregnancies:
- 0  1  2  3  4  
 5  more than 5 Number of C-Sections:
- breech  failure to progress  
 fetal distress  repeat C-Section  
 herpes  oversized baby  
 other Reason for C-Sections:  
(Mark all that apply.)
- yes  no Any complications of pregnancy?
- breech  high blood pressure  
 bleeding  pre-term delivery  
 diabetes  pre-term rupture of membranes  
 premature labor  other If yes, please mark all complications.
- yes  no Any problems getting pregnant?

This form will be electronically scanned. To ensure that your feedback is properly recorded, make sure you have followed the marking instructions on the first page. Thank you for taking the time to complete this questionnaire!