

**ANNUAL GYNECOLOGIC EXAMINATION HEALTH QUESTIONNAIRE
PLEASE COMPLETE THIS FORM BEFORE YOUR VISIT**

Name _____ Marital Status _____ Age _____ Date _____

Address _____ City _____ State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Date of Birth _____ Social Security Number _____

Employer _____ Occupation _____

Emergency Contact _____

Emergency Contact Phone Number _____

Primary Care Physician _____

Primary Care Physician Phone Number _____

GYNECOLOGIC HISTORY

How many pregnancies have you had? _____ How many live births? _____

When was the first day of your last period? _____

Please circle YES or NO:

YES NO OCC Do you have periods? How many days apart are they? _____

YES NO OCC Are your periods regular?

YES NO OCC Are your periods heavy?

YES NO OCC Do you have bleeding between your periods?

YES NO OCC Are you sexually active?

YES NO OCC Are you troubled with a vaginal discharge?

YES NO OCC Do you have pain with intercourse?

YES NO OCC Do you have hot flashes

YES NO OCC Are you troubled with leakage of urine (incontinence)?

YES NO OCC Do you have a protrusion/prolapse from the vagina?

YES NO Have you ever had an abnormal pap test?

YES NO Have you ever had a Sexually Transmitted Disease (STD)?

YES NO Have you had the Gardasil (HPV) vaccine series?

Have you had any new medical problems or surgeries since your last visit? If so, please elaborate.

Please list all medications including vitamins and herbal supplements:

Please list any allergies to medications: _____

Has any of your family members (blood relatives) had any new medical problems since your last visit? If so, please explain.

When was your last mammogram? _____

When was your last osteoporosis screening test? _____

When was your last screening stool test or colonoscopy? _____

YES NO OCC Do you smoke? If yes, how much per day? _____

YES NO OCC Do you drink alcohol? _____

Are you currently experiencing any of the following? If yes, circle and explain.

SYMPTOMS	YES	NO	If you answered YES, please explain:
1. Constitutional: Weight loss, fatigue, fever			
2. Eyes: visual changes, blurred vision			
3. Ears, nose, mouth, throat: Hearing loss, nosebleeds			
4. Cardiovascular: Chest pain, swelling in extremities			
5. Respiratory: Shortness of breath, chronic cough, wheezing			
6. Gastrointestinal: Diarrhea, Constipation, Blood in stool, nausea, vomiting			
7. Genitourinary: Pain with urination, frequency of urination, leakage of urine			
8. Musculoskeletal: Back pain, Neck pain			
9. Neurological: Headaches, Numbness, Dizziness, Seizures			
10. Psychiatric: Depression, Anxiety, Frequent Crying			
11. Endocrine: Heart palpitations, unexplained weight gain, heat or cold intolerance			
12. Skin: Rash, breast lumps			
13. Blood/lymph: swollen glands, excessive bleeding			
14. Allergy/Immunology: Allergic reaction, frequent infections			

I hereby authorize the office of Premier Women's Health to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. I authorize this office to use "FAX" as a means of rapid communication with other physician's offices, pharmacies, laboratories, and insurance companies that are pertinent to my care. I understand that this office follows HIPAA protocols and protects my privacy as a patient.

I have read and understand the above statements.

Date: _____ Signature: _____