THE OB/GYN GROUP OF AUSTIN PATIENT HISTORY QUESTIONNAIRE **GW ACCT#**

Although some of the information requested below may not seem pertinent, it helps us provide you with the best care. We ask that you fill out ALL of the following questions completely.

Date _____Name _____ Birth Date _____ Age _____ Race/Ethnicity _____

Phone: Home_____ Work_____ Cell _____ Email _____

Preferred Pharmacy: Name _____Address _____Zip Code_____ Phone _____

Is there someone we can thank for referring you? _____ Primary Physician _____

Physician/Provider: Abikhaled Gooch Grogono Kish McCoin Nunnelly Reue Hoverman Rowan PA Spring NP Palmer NP

REASON FOR YOUR VISIT TODAY: (details if necessary)

_____

Date of last **Annual Exam**_____ Date of Last **Pap Smear** _____
Have Paps ever been Abnormal? _____ Did you receive any treatment? When? _____
Have you ever had a **Mammogram**?_____ Date/Results:_____
Have you ever had a **Bone Density Scan**? _____ Date/Results:_____
Have you ever had a **Colonoscopy/flexsigmoidoscopy**? Date/Results:_____
Have you ever had a **Blood Transfusion**? (List date/reason) _____
Would you **accept blood or blood products** in case of an emergency? _____ If not, please explain_____
Have you ever had **Chicken Pox**? _____
Have you ever had complications with **Anesthesia** of any kind? Please explain_____
Did your mother receive a drug called DES when she was pregnant with you? _____

REPRODUCTIVE HISTORY

Age at 1st period _____ How far apart are your cycles (ex.28days) _____ How many days do you bleed (i.e. 5days)_____

Menstrual flow (please circle): Light Medium Heavy Is menstrual pain or cramping a problem for you? YES NO

When was the FIRST day of your **last period**? _____ How **certain** are you: □ Very □ Somewhat □ Not at all

What is your current birth control method? (Please choose one):

Nothing… Condoms… Pills/Ring/Patch… IUD… Tubal… Vasectomy… Menopause… Hysterectomy… Other: _____

Do you desire a change to your current birth control method? _____

Are you Menopausal: □ N/A □ Yes □ No Age at Menopause: _____ Are you on hormones? Type? _____

Total # of pregnancies _____ Total # of live children _____ # of Abortions (list dates)_____
Miscarriages or Ectopics (list dates & how far along you were): _____

Date of Delivery	# Weeks Pregnant	Hours in Labor	Birth Weight	Sex & Name	Delivery Type	Anesthesia Type	Location	Complications (i.e. preterm labor)

SURGICAL HX

Please list any surgeries or hospitalizations you have undergone (D&C, Hysterectomy, Cesarean Section)

Year of Surgery Type / Reason for MD Hospital

_____

_____

_____

DATE: _____ **SIGNATURE:** _____ **UPDATED 2/1/17**

SOCIAL HISTORY

Marital Status (please check one):
_____Single/Not Dating _____Married
_____Singe/ Dating _____Divorced
_____In a committed relationship _____Widowed
_____Engaged

PARTNER'S NAME: _____ **Age:**_____

Safety: Do you feel safe in your current relationship: Yes No
If not please explain_____

Have you ever been physically abused in a relationship: Yes No
If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
If so, please let us know when this occurred: _____
_____

Substance Use: Do you drink alcohol: Yes No
How many drinks per day or week: _____
Do you currently use any illicit drugs: Yes No
Type _____
How often _____
Do you smoke cigarettes: Yes No Never Current Former
How many per day _____
How long have you been a smoker: _____

Occupation: _____

Do you Exercise: Yes No
Type _____
How often _____

Infection Risk:
Are you currently sexually active? Yes No
Sexual preference (circle one): Heterosexual Lesbian Bisexual
How many sexual partners in the last 1 year? _____
In your lifetime: 1-5__ 5-10__ 10-20__ 20+___

Have you ever had a sexually transmitted disease (STD)?: Yes No
Hepatitis (Type?) _____
Syphilis (when? treated?) _____
Chlamydia (when? treated?) _____
Gonorrhea (when? treated?) _____
Genital Herpes (taking meds?) _____
HPV (human papilloma virus) _____
Genital warts? _____
HIV _____
OTHER _____

Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)?
Yes No

PAST MEDICAL HX & FAMILY HX

(PLEASE PLACE AN "X" IN THE WHITE BOXES THAT APPLY)

	YOU	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or sisters	Children	OTHER family member
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida…..)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (ex. ITP, sickle cell…)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis…)										
Glaucoma										
Heart disease or MVP										
High cholesterol										
High blood pressure										
Kidney Disease/stones										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disease										
Uterine anomalies										
…Still Living?	**X**									
…Deceased at Age?	**----**									

DATE: _____ **SIGNATURE:** _____ **UPDATED 2/1/17**

Meds & Allergies

List **Drug Allergies** (and the Reaction you had):

_____
_____
_____
_____
_____
_____
_____

List **all medications** (include over-the-counter and supplements), **Doses**, the **Reason** you are taking, and **Who prescribes** it:

_____
_____
_____
_____
_____
_____

REVIEW OF SYMPTOMS

Constitutional:	**Circle One**:		
Frequent Fatigue	Present	Past	N/A
Excess weight gain	Present	Past	N/A
Excess weight loss	Present	Past	N/A
Eyes, Ears, Nose, Mouth:	**Circle One:**		
Frequent or severe headaches	Present	Past	N/A
Frequent lightheadedness	Present	Past	N/A
Breasts:	**Circle One**:		
Lumps	Present	Past	N/A
Pain	Present	Past	N/A
Swelling	Present	Past	N/A
Nipple discharge	Present	Past	N/A
Cardiovascular:	**Circle One:**		
Chest pain	Present	Past	N/A
Fainting	Present	Past	N/A
Swollen/Painful varicose veins	Present	Past	N/A
Calf pain	Present	Past	N/A
Respiratory:	**Circle One**:		
Frequent shortness of breath	Present	Past	N/A
Frequent Hoarseness	Present	Past	N/A
Gastrointestinal:	**Circle One**:		
Nausea/ Vomiting	Present	Past	N/A
Frequent Diarrhea	Present	Past	N/A
Frequent Constipation	Present	Past	N/A
Frequent Heartburn/ reflux	Present	Past	N/A
Abdominal Pain	Present	Past	N/A
Blood in stool	Present	Past	N/A
Hemorrhoids	Present	Past	N/A
Genitourinary:	**Circle One:**		
Urgency	Present	Past	N/A
Frequency	Present	Past	N/A
Pain with urination	Present	Past	N/A
Blood in urine	Present	Past	N/A
Frequent Urine leakage	Present	Past	N/A
Pain with intercourse	Present	Past	N/A
Genital sores	Present	Past	N/A

Genitourinary (continued)	**Circle One:**		
Irregular periods	Present	Past	N/A
Painful periods	Present	Past	N/A
Heavy periods	Present	Past	N/A
No periods	Present	Past	N/A
Possible pregnancy?	Present	Past	N/A
Abnormal vaginal discharge	Present	Past	N/A
Significant PMS	Present	Past	N/A
Integument (skin):	**Circle One:**		
New skin lesions	Present	Past	N/A
Changes to moles/skin lesions	Present	Past	N/A
Musculoskeletal:	**Circle One:**		
Joint pain	Present	Past	N/A
Joint swelling	Present	Past	N/A
Recent back pain	Present	Past	N/A
Endocrine:	**Circle One**:		
Excess bodily hair growth	Present	Past	N/A
Excess hair loss	Present	Past	N/A
Cold intolerance	Present	Past	N/A
Heat intolerance	Present	Past	N/A
Acne	Present	Past	N/A
Thyroid abnormalities/ treatment?	Present	Past	N/A
Psychiatric:	**Circle One:**		
Frequent Anxiety	Present	Past	N/A
Frequent Depression	Present	Past	N/A
Suicidal thoughts	Present	Past	N/A
Psychiatric treatment	Present	Past	N/A
Hematologic/Lymphatic:	**Circle One:**		
Easy bleeding	Present	Past	N/A
Easy bruising	Present	Past	N/A

LIST ANY OTHER SYMPTOMS BOTHERING YOU TODAY:

_____
_____
_____
_____
_____

YOUR HEIGHT: **YOUR WEIGHT:**

DATE: _____ **SIGNATURE:** _____ **UPDATED 2/1/17**