CHRISTIAN HEALTHCARE CENTERS

Name _____

DOB _____

Today's Date_____

OB/Gyn Health History Questionnaire

1. Menstrual History					
Age at onset of menstruation _____					
First day of last menstrual period _____	Or	Starting date of menopause _____			
Periods occur every _____ days					
Periods last for _____ days					
Period flow			□ Light	□ Normal	□ Heavy
Period cramps		□ None	□ Mild	□ Moderate	□ Severe

2. Obstetric History

Pregnancy #	Month Year	Comp-lications	Term Vaginal	Term Cesarean	Preterm Vaginal	Preterm Cesarean	Mis-carriage	Abortion	Ectopic

3. Cervical Cancer Screening		
When was your last Pap smear _____		
Have you ever had an abnormal Pap smear	□ Yes	□ No
If yes, when and how were you treated _____		
What was the diagnosis _____		
Have you ever had HPV	□ Yes	□ No
Have you received all 3 doses of the HPV vaccine	□ Yes	□ No

4. Sexually Transmitted Infections			
Are you sexually active		□ Yes	□ No
Do you have concerns regarding your sex life		□ Yes	□ No
Do you have pain with sex		□ Yes	□ No
Have you ever had	□ Gonorrhea □ Chlamydia	□ Pelvic Inflammatory Disease	
If yes, when, how and where were you treated _____			
Have you ever had Herpes		□ Yes	□ No
If yes, where do you have outbreaks _____			
If yes, how often do you have outbreaks _____			
Have you ever had syphillis		□ Yes	□ No

5. Family Planning		
Are you using anything to prevent pregnancy	□ Yes	□ No
If yes, what method _____		
If no, are you taking prenatal vitamins	□ Yes	□ No
Have you been treated for infertility	□ Yes	□ No
If yes, where, when and how _____		

6. Bladder and Bowel		
Painful urination	□ Yes	□ No
Recurrent urinary tract infections (≥3 in 12 months)	□ Yes	□ No
Blood in urine	□ Yes	□ No
Do you leak urine (circle)	□ Yes	□ No
With cough		
With exercise		
Without activity		
If you leak urine, how much (circle)		
Few drops		
Panty liner full		
Require depends		
If you leak urine, how often (circle)		
Few times per week		
Once per day		
Multiple times per day		
If you leak urine, how bothersome (circle)		
None		
Mildly bothersome		
Interferes with daily activities		
Peeing at night (circle)	□ Yes	□ No
1x per night		
1-2x per night		
>2x per night		
Do you leak stool	□ Yes	□ No
Do you have constipation	□ Yes	□ No
Do you have to push on your vagina or sit a certain way to have a stool	□ Yes	□ No

7. Pelvic Floor		
Vaginal bulge or pressure	□ Yes	□ No
Small		
Medium		
Large		
If you have a vaginal bulge, does it hurt	□ Yes	□ No
If you have a vaginal bulge, does it bleed	□ Yes	□ No
If you have a vaginal bulge, how bothersome (circle)		
None		
Mildly bothersome		
Interferes with daily activities		
Abnormal vaginal discharge	□ Yes	□ No
Vaginal or vulvar pain	□ Yes	□ No
Vaginal or vulvar lesions	□ Yes	□ No

8. Breast Health		
Breast tenderness	□ Yes	□ No
Brest lump	□ Yes	□ No
Side _____	□ Yes	□ No
Breast discharge		
Color _____		

9. Perimenopause and Menopause		
Hot flashes	□ Yes	□ No
Night sweats	□ Yes	□ No
Vaginal dryness	□ Yes	□ No
Irritability	□ Yes	□ No

10. Social		
Do you have any problems (eg, job, transportation) that prevent you from keeping your health care appointments	□ Yes	□ No
Do you feel safe where you live	□ Yes	□ No
Are you exposed to second-hand smoke	□ Yes	□ No
In the past 2 months, have you used any tobacco (smoked, chewed, vaped, nicotine replacement)	□ Yes	□ No
In the past 2 months, have you used alcohol (beer, wine, or mixed drinks)	□ Yes	□ No
In the past 2 months, have you used drugs (marijuana, IV drugs)	□ Yes	□ No
In the past year, has anyone threatened, hit, slapped, or kicked you	□ Yes	□ No
Has anyone ever forced you to perform any sexual act that you did not want to do	□ Yes	□ No
How many times have you moved in the past 12 months	_____	

11. Family History		
Bleeding or clotting disorders	□ Yes	□ No
Blood clot in lungs or DVT	□ Yes	□ No
Birth defect	□ Yes	□ No
Hypertension	□ Yes	□ No
Diabetes	□ Yes	□ No
Heart disease	□ Yes	□ No
Breast cancer	□ Yes	□ No
Ovarian cancer	□ Yes	□ No
Uterine cancer	□ Yes	□ No
Colon cancer	□ Yes	□ No

13. Spiritual History		
On a 1–5 scale, how do you rate your current stress level?	Low 1 □ 2 □ 3 □ 4 □ 5 □ High	
How do you deal with stress?	Well 1 □ 2 □ 3 □ 4 □ 5 □ Poorly	
Do you believe in God?	□ Yes	□ No
Do you turn to God when you feel stressed?	□ Yes	□ No
Are you happy with your relationship with God?	Yes 1 □ 2 □ 3 □ 4 □ 5 □	□ No