WENTWORTH HEALTH PARTNERS

OB/Gyn & Infertility Patient Health Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Reason for Visit: _____

Allergies: _____

Medications: _____

SOCIAL HISTORY:

Smoking History (circle type): Current ____ Quit ____ When _____ Never ____
Tobacco/Cigars/Marijuana Amt/Day ____ # of years ____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING COMPLAINTS PLEASE CHECK OFF YES or NO & CIRCLE ALL THAT APPLY:

Yes	No		Yes	No		Yes	No	
___	___	Recent Weight loss / Gain	___	___	Abdominal Pain	___	___	Vaginal Itching
___	___	Fever/Chills	___	___	Nausea/Vomiting	___	___	Vaginal Pain/Odor
___	___	Vision Changes / Glasses	___	___	Diarrhea	___	___	Limb Pain/Joint Pain
___	___	Nose Bleeds/Sore Throat	___	___	Urinary Frequency	___	___	Breast Pain/Lump
___	___	Loss of Hearing	___	___	Difficulty Emptying Bladder	___	___	Headaches/Migraines
___	___	Chest Pain/Palpitations	___	___	Irregular Menses	___	___	Anxiety/Depression
___	___	Leg Swelling	___	___	Pain w/Menses	___	___	Hot Flashes
___	___	Shortness of Breath	___	___	Pain w/Intercourse	___	___	Other: _____
___	___	Cough	___	___	Easy Bleeding/Bruising	___	___	Other: _____

Last Menstrual Period: _____ Age of 1st Menstrual Period: _____
Current Form of Birth Control: _____ Last PAP: _____
Last Mammogram: _____ Last Colonoscopy: _____
Last Bone Density: _____

PREGNANCY HISTORY:

		Yes / No	Miscarriage		Yes / No	Abortion
Mo/Yr.	Hospital	Sex	Wt.	Weeks	Vag/C-S	Complications
Mo/Yr.	Hospital	Sex	Wt.	Weeks	Vag/C-S	Complications
Mo/Yr.	Hospital	Sex	Wt.	Weeks	Vag/C-S	Complications
Mo/Yr.	Hospital	Sex	Wt.	Weeks	Vag/C-S	Complications
Mo/Yr.	Hospital	Sex	Wt.	Weeks	Vag/C-S	Complications

PLEASE COMPLETE BACK OF FORM

Patient Name: _____
DOB: _____

PAST SURGICAL HISTORY:

_____ Tonsils/Adenoids _____ Gallbladder _____ Appendectomy _____Tubal Ligation
Other: _____
_____
_____

PAST PERSONAL & FAMILY HISTORY: Check off Yes or No and put S= Self, P= Paternal, M= Maternal & Relationship (Example: M - Grandmother)

Yes	No		Yes	No	
___	___	High Blood Pressure _____	___	___	Stroke _____
___	___	Heart Problem _____	___	___	Liver Problems _____
___	___	Bleeding Disorder _____	___	___	Anemia _____
___	___	Clotting Disorder _____	___	___	Diabetes _____
___	___	Thyroid Problems _____	___	___	Kidney Problems _____
___	___	Breast Cancer _____	___	___	Inherited Disorder _____
___	___	Ovarian Cancer _____	___	___	Alcohol/Drug _____
___	___	Uterine Cancer _____	___	___	High Cholesterol _____
___	___	Colon Cancer _____	___	___	Anxiety _____
___	___	Other Cancer _____	___	___	Depression_____
___	___	Chicken Pox _____	___	___	Birth Defects _____
___	___	Eating Disorder_____	___	___	Other: _____

GYNECOLOGIC HISTORY: Do you have a history of:

Yes	No	
___	___	DES Exposure
___	___	Breast Problems
___	___	Abnormal PAP Smears Treatments: _____
___	___	Endometriosis
___	___	Ovarian Cysts
___	___	Polycystic Ovarian Syndrome
___	___	Uterine Fibroids
___	___	Abnormal Bleeding
___	___	Vaginal Infections
___	___	Syphilis
___	___	Chlamydia
___	___	Warts
___	___	Herpes
___	___	HIV
___	___	Hepatitis C
___	___	Other Sexually Transmitted Diseases: _____