Matagorda Episcopal Health Outreach Program

Women's Health Questionnaire

Please complete the following information:

Name:	Date:
Referring Physician:	Primary Care Provider:
Date of Birth:	Age:
Phone Number:	Email address:
Preferred Pharmacy Name:	Preferred Pharmacy Number:
Why Are You Here?	
What symptoms are you having? What work-up (labs, X-ray, etc.) have already been done?	
GYNECOLOGIC HISTORY	
When was your last pap smear? Have you ever had an abnormal pap smear? □ Yes □ No	If yes, when and what treatment was prescribed? □repeat pap □Colposcopy □LEEP/Conization □Other
Are you sexually active? □ Yes □ No If so how many current partners do you have?	What is your current contraceptive method? □ abstinence □ pills □ condoms □ patch □ intrauterine device □ implant □ tubal ligation □ vasectomy □ other
Are you menopausal? □ Yes □ No If yes, what age were you?	Have you ever taken hormonal therapy? □ Yes □ No If yes, what kind?
Have you had trouble with Infertility? □ Yes □ No If yes, what type of treatment has been done?	Do you have any know uterine abnormalities?
Have you ever had a mammogram? □ Yes □ No If yes, when & where was your last one? Have you ever had an abnormal mammogram? □Yes □No	Have you ever had any of the following: □ Chlamydia □ Syphillis □ Gonorrhea □ Genital Herpes □ HIV □ Genital warts □ PID □Other
Have you ever had a colonoscopy? □ Yes □ No If yes, when & with which doctor?	Have you ever had a bone density scan? □ Yes □ No If yes, when & where was your last one?

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OBSTETRICAL HISTORY	
How many times have you been pregnant?	How many children did you give birth to? How many vaginal deliveries? How many c/sections?
How many miscarriages have you had? Did you require a D&C?	Have you ever had an ectopic/tubal pregnancy? If yes, how many and what treatment was performed?
Have you ever terminated a pregnancy? If yes, how many?	Are you planning to have more children in the future? ☐ Yes ☐ No
MENSTRUAL HISTORY	
First Day of last menstrual period: Check if normal amount/duration: ☐	Do you have monthly menstrual cycles? ☐ Yes ☐ No
How certain are you of your last menstrual cycle? ☐ Definite ☐ Uknown ☐ Approximate (month known)	Number of days between periods:
Age when periods began:	Do You Have Problems With You Menstrual Cycle? ☐ Yes ☐No If Yes, What?
Do you have heavy bleeding with your cycle? ☐ Yes ☐ No If yes, please explain:	Do you have pain with your menstrual cycles? ☐ Yes ☐ No If yes, please explain:

MEDICAL HISTORY

Please check any current or past medical problems for yourself:

	Yes	No		Yes	No
Diabetes			Stroke		
Hypertension			Asthma		
Heart Disease			Lung problems		
Autoimmune Disorder			Seasonal Allergies		
Kidney Disease			Neurologic Disease		
Seizures			Anxiety		
Depression			Skin Disease		
Hepatitis			Liver Disease		
Blood clots in the legs/lungs			Spider Veins		
Thyroid Disorder			Trauma		
Domestic Violence			History of Blood Transfusion		
Chronic Pain			Bleeding Disorder		
Anesthetic complications			Infertility		
Cancer			If cancer, what type?		

Other:

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SURGICAL HISTORY		
Please list all surgeries you have ever had and include c/sections, D&C, and any procedures:		
Surgery Type	Date of surgery	Reason for Surgery

CURRENT MEDICATIONS					
Please list any medications you are taking including prenatal vitamins, birth control pills, Tylenol, Advil, Aspirin, herbal and non-prescription medications.					
Medication Name	Dose	Frequency of Dose	Medication Name	Dose	Frequency of Dose

ALLERGIES		
Do you have any medication allergies? □ Yes □ No	If yes, to what?	What type of reaction do you have?
Do you have any food/latex allergies? □ Yes □ No	If yes, to what?	What type of reaction do you have?

SOCIAL HISTORY			
Do you use tobacco? □Yes □ No	What type? □cigarettes □ chewing	For how many years?	How much per day?
Did you previously use tobacco? □ Yes □ No		For how many years?	When did you quit?
Do you use alcohol □ Yes □ No		For how many years?	How much per day?
Do you use illicit drugs? □ Yes □ No If yes, what type: □ Marijuana □ Cocaine □ Heroine □ Amphetamines □Other		For how many years?	How much per day?
Occupation:		Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Engaged	
Place of Employment:			

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FAMILY HISTORY			
	Yes	**No**	
Is your mother living?			Please list any medical conditions for which she is being treated for or has had:
What is her current age or age at the time of death?			
Is your father living?			Please list any medical conditions for which he is being treated for or has had:
What is his current age or age the time of death?			
Do you have any brothers/sisters?			Please list any medical conditions:
History of Ovarian Cancer?			If so, which family members?
History of Breast Cancer?			If so, which family members?
History of Colon Cancer?			If so, which family members?
History of Uterine Cancer?			If so, which family members?
History of Hypertension?			If so, which family members?
History of Diabetes?			If so, which family members?
Please list any other family illnesses:			
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REVIEW OF SYSTEMS							
Please answer yes if you have experienced any of the following symptoms within the last month:							
		Yes	**No**			**Yes**	**No**
Constitutional	Fatigue			**Urinary**	Urgency		
	Fever				Frequency		
	Weight Loss/Gain				Dysuria (painful urination)		
	Night Sweats				Incontinence		
	Changes in Appetite			**Skin**	Changes in existing moles/lesions		
Gynecologic	Vaginal bleeding				Rash		
	Vaginal discharge				Itching		
	Pelvic Pain			**ENT**	Decreased Hearing		
	Vaginal Itching				Sore Throat		
Eyes	Wear glasses			**Musculoskeletal**	Muscle Aches		
	Wear contacts				Arthritis		
	Blurred vision				Chronic Back Pain		
Neurologic	Weakness			**Gastrointestinal**	Nausea		
	Dizziness				Vomiting		
	Vertigo				Diarrhea		
	Headaches				Constipation		
	If yes, what type? □ sinus □ migraine □ tension			**Endocrine**	Hot flashes		
Breasts	Lumps				Hair Loss/Growth		
	Tenderness				Cold Intolerance		
	Nipple Discharge				Heat Intolerance		
Cardiovascular	Chest pain			**Psychiatric**	Anxiety		
	Irregular Heart Beat				Depression		
	Palpitations				Difficulty Sleeping		
	Leg swelling			**Hematologic/Lymphatic**	Easy Bruising		
Respiratory	Shortness of Breath				Excessive Bleeding		
	Wheezing			**Allergic/Immunologic**	Allergy Symptoms		
	Cough				HIV risk factors (IV drug use, high risk sexual behavior)		
Comments:							
Reviewer's Name:				**Reviewer's Signature:**			

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