Hays Women's Health

Return GYN Questionnaire

*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: ____

Address: ____

Phone # (Home/Cell): __________________________ DOB: _______________________________Age: ________

Reason for visit: ____

Preferred Pharmacy: ____

Please list any medications that you are currently taking (include herbal and over the counter): _____________

____

Please list any changes to your medical, surgical or family history since your last visit to our office: _________

____

Please list any changes to your social history since your last visit (relationship status, new sexual partner, new job, change in tobacco, alcohol, or drug use): ____

____

When was the first day of your last menstrual period (if applicable)? __________________________________

____

Are your periods ❑ regular? ❑ irregular?

How many days do you have bleeding? __________ How often do your periods occur? ___________________

Do you have any concerns about your menses / periods you would like addressed? ❑ yes ❑ No

If so, please list: ____

If you are currently sexually active, please indicate which of the following you use for birth control:

❑None/Attempting Conception ❑Withdrawal ❑Condoms ❑Combined Hormone (pill/patch/ring)

❑Progesterone pill ❑DepoProvera ❑IUD ❑Implanon ❑Tubal Ligation/Occlusion ❑Vasectomy

❑Menopause ❑Hysterectomy ❑Female Partner/Not applicable ❑Other: ______________________

If applicable, please list the name of birth control pills/ring/patch/IUD: _________________________________

If you have any concerns about your current birth control method, please explain: _______________________

____

____

Name: ____ DOB: ____________________

ACOG Recommendations

The American College of Obstetrics and Gynecology (ACOG) recommends:

HIV screening for all women ages 19-64
HIV screening for sexually active teenagers under age of 19
HIV screening for women older than 64 who have had multiple partners in recent years
Annual chlamydia screening of all sexually active women age 25 and younger
HPV (Human Papilloma Virus) screening, in addition to a pap smear, for women over the age of 30

I would like to discuss STD screening today. (*We cannot guarantee insurance coverage for any tests.*)

Review of Symptoms
Are you currently experiencing any of the following symptoms?

Constitutional:	❑None	❑Weight loss ❑Weight gain ❑Fever ❑Fatigue ❑Change in height
Eyes:	❑None	❑Vision change ❑Glasses/contacts ❑Double vision
Ears, Nose, Throat:	❑None	❑Sinus problems ❑Hearing problems ❑Ear aches ❑Sore throat
Cardiovascular:	❑None	❑Chest pain ❑Shortness of breath on exertion ❑Swelling of legs ❑Palpitations or Irregular heart beat
Respiratory:	❑None	❑Wheezing ❑Coughing up blood ❑Shortness of breath ❑Cough
Gastrointestinal:	❑None	❑Frequent diarrhea ❑Bloody stool ❑Nausea/vomiting/indigestion ❑Constipation ❑ Involuntary loss of gas or stool
Genitourinary:	❑None	❑Blood in urine ❑Pain with urination ❑Urinary urgency ❑Urinary frequency ❑Incomplete urinary emptying ❑Urinary incontinence (leaking) ❑Abnormal bleeding ❑Pain with intercourse ❑Abnormal vaginal discharge ❑Irregular periods ❑Painful periods ❑Heavy periods ❑Significant PMS
Musculoskeletal:	❑None	❑Muscle weakness ❑Muscle or joint pain ❑Muscle cramps
Skin/Breast:	❑None	❑Changes in skin lesions or moles ❑New skin lesions ❑Rash ❑Breast pain ❑Nipple discharge ❑Breast mass/lump
Neurological:	❑None	❑Hand or leg weakness ❑Seizures ❑Numbness ❑Trouble walking ❑Severe memory problems ❑Dizziness ❑Frequent or severe headache
Psychiatric:	❑None	❑Depression ❑Frequent crying ❑Anxiety ❑Suicidal thoughts
Endocrine:	❑None	❑Hot flashes ❑Heat/Cold intolerance ❑Excessive thirst ❑Excessive hair loss ❑Excessive hair growth ❑Acne
Blood / Lymphatic:	❑None	❑Bruises easily ❑Bleeds easily ❑Swollen lymph nodes (glands) ❑Previous blood transfusions
Allergies/Immune:	❑None	❑Food allergies ❑Recurrent infections ❑Problems with anesthesia