UCLA Health System

MRN:
Patient Name:

(Patient Label)

Department of Obstetrics and Gynecology

PATIENT HISTORY QUESTIONNAIRE

A

1. Marital Status: ☐ Single ☐ Married ☐ Long term Relationship ☐ Divorced ☐ Widowed
2. Reason for this visit: _____
3. Referring Physician: _____
4. Occupation:_____
5. Preferred phone number: _____ confidential voice mails OK: ☐ Yes ☐ No
6. Partner: _____ ☐ None 7. Age of partner: _____
   last first 8. Occupation of partner: _____

B MENSTRUAL HISTORY(complete even if post-menopausal or no longer having periods)

7. Age at first period: _____ years.
8. If your menstrual periods are regular; periods start every: _____ days
9. If your menstrual periods are irregular; periods start every:____ to ____ days (e.g.,12 to 60)
10. Duration of bleeding: _____ days
11. Does bleeding or spotting occur between periods? Yes ☐ No ☐
12. Does bleeding or spotting occur after intercourse? Yes ☐ No ☐
13. First day of last menstrual period _____
    month day year
14. Is pain associated with periods? Yes ☐ No ☐ Occasionally ☐
15. If yes to 14, is it: before menses? ☐ during menses? ☐ both? ☐

C PREGNANCY HISTORY (All pregnancies) Have never been pregnant ☐

16. OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

						CHILD		
Year	Place of delivery or Abortion	Duration Preg.	Hrs. of Labor	Type of Delivery	Complications Mother and/or Infant	Sex	Birth Weight	Present Health

D BIRTH CONTROL HISTORY

17. What birth control method(s) do you currently use? _____

E SEXUAL HISTORY

18. Do you have a sexual partner? No ☐ Yes ☐ (Male ☐ Female ☐)
19. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes ☐ No ☐

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F PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

20. Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR
☐ D&C		☐ ovarian surgery	
☐ hysteroscopy		☐ L cyst(s) removed ovarian	
☐ infertility surgery		☐ R cyst(s) removed ovarian	
☐ tuboplasty		☐ L ovary removed	
☐ tubal ligation		☐ R ovary removed	
☐ laparoscopy		☐ vaginal or bladder repair for prolapsed or incontinence	
☐ hysterectomy (vaginal)		☐ cesarean section	
☐ hysterectomy (abdominal)		☐ other (specify) _____	
☐ myomectomy			

G PAST SURGICAL HISTORY (Not OB/GYN)

21. List all surgeries and their year or ☐ None

Surgeries	Year

H PAP SMEAR/MAMMOGRAM HISTORY

22. ☐ Date of last pap smear: _____

23. ☐ Have you had abnormal pap smears? No ☐ Yes ☐

24. ☐ Have you had treatment for abnormal smears? No ☐ Yes ☐

If yes, what type(s) of treatment have you had?

	YEAR
cryotherapy	
laser	
cone biopsy	
loop excision (LEEP)	

25. Date of last mammogram: _____ (month) _____ (year)

26. Have you had an abnormal mammogram? No ☐ Yes ☐

OTHER PAST GYNECOLOGICAL HISTORY

27. Check any that apply: ☐ None ☐ Venereal warts ☐ Herpes – genital ☐ Syphilis
☐ Pelvic inflammatory disease ☐ Endometriosis ☐ Chlamydia ☐ Gonorrhea
☐ Vaginal infections ☐ Other _____

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I PAST MEDICAL HISTORY Check any that apply: or ☐ None

☐ Arthritis
☐ Diabetes:
  ☐ Diet controlled
  ☐ Pill controlled
  ☐ Insulin controlled
☐ High blood pressure
☐ Heart disease
☐ Kidney Disease
☐ Gallstones
☐ Liver Disease (including hepatitis)
☐ Epilepsy
☐ Blood Transfusions
☐ Thyroid disease
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ HIV+
☐ Eating Disorder
☐ Other: _____

J CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

K DO YOU CURRENTLY?:

28. Smoke No ☐ Yes ☐ ____ packs/day
29. Use alcohol No ☐ Yes ☐ __ wine (glasses/day); __ beer (bottles/day); __ hard liquid (oz./day)

30. Use illicit drugs No ☐ Yes ☐ _____ type _____ amount
31. Exercise: Type: _____ How often _____

L DRUG ALLERGIES

32. No ☐ Yes ☐ List:

_____

_____

_____

M FAMILY HISTORY

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other
☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer _____
_____

If "yes" to any, please list affected relatives

_____ _____

_____ _____

☐ None of the above.

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N OTHER SYMPTOMS

Have you had recent?:

- ☐ weight loss
- ☐ weight gain
- ☐ change in energy
- ☐ change in exercise tolerance
- ☐ hair growth
- ☐ hair loss
- ☐ change in urinary function
- ☐ hot flushes/flashing
- ☐ breast discharge
- ☐ none of the above
- ☐ Other _____
- _____

O

Note: Fill out Section "O" only if you are pregnant or planning to be pregnant in the near future.

Have you or the baby's father or anyone in your families ever had any of the following:

☐ Down Syndrome (Mongolism)? If yes, who?_____

☐ Other Chromosomal abnormality? If yes, specify _____

☐ Neural tube defect (spina bifida, anencephaly)? If yes, who? _____

☐ Hemophilia or other coagulation abnormality? If yes, who? _____

☐ Muscular Dystrophy? If yes, who? _____

☐ Cystic Fibrosis? If yes, who? _____

☐ If you or the baby's biological father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

- ☐ Father Result _____
- ☐ Mother Result _____

☐ If you or the baby's biological father are of African ancestry, have either of you been screened for Sickle cell trait?

- ☐ Father Result _____
- ☐ Mother Result _____

☐ If you or the baby's biological father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalessemia?

- ☐ Father Result _____
- ☐ Mother Result _____

☐ If you or the baby's biological father are of Philippine or Southeast Asian ancestry, have either of you been tested for A-thalessemia?

- ☐ Father Result _____
- ☐ Mother Result _____

_____ _____ _____

PATIENT SIGNATURE DATE TIME

_____ _____ _____

PHYSICIAN SIGNATURE DATE TIME