TRI-STATE OB/GYN QUESTIONAIRE

Name_____Birthdate_____Age____SS#_____Date_____
Address_____City/State_____Zip_____
Home Phone_____Cell_____Work_____
Occupation_____Employer_____Medical Insurance_____
Marital Status: M S W D Husbands Name_____ PCP_____

PAST MEDICAL HISTORY (check if you have ever had any of the following):

__Heart Attack
__Congestive heart failure
__Abnormal heart rhythm
__Atrial-Fib
__Asthma
__COPD/ Chronic bronchitis
__Emphysema
__Pneumonia
__Acid reflux/Hiatal hernia
__Ulcers
__High blood pressure
__Liver disease
__Diabetes
__Blood clots
__Von Willebrands
__Hemophilia
__Epilspsy/Siezures
__Migraines
__Kidney disease
__Kidney stones
__Gallstones
__Broken bones/ Osteoporosis
__Anemia
__Depression/ Bipolar
__Anxiety
__Alcohol or drug abuse
__Fibromyalgia
__Lupus/Autoimmune disease
__Interstitial cystitis
__Overactive bladder
__Irritable bowel/Colitis/Chron's

__Cancer type_____Treatment_____Year_____
Other_____
Explain any of the above that you checked_____

We now do electronic prescriptions. Please provide us with the name of the pharmacy that you prefer your prescription to be sent to.
Local pharmacy_____ City_____
Mail order pharmacy_____

Medications: (include herbals, vitamins, and over the counter medications)

Medicine	Dose	How Taken	Reason

Allergies: Please circle: Latex, Betadine, Tape, IVP Dye
Please list all medical allergies below

Medicine	Reaction	Medicine	Reaction

PAST SURGICAL HISTORY (check all that you have had):

__D &C __Tubal Ligation __Bladder repair
__Tonsils __Gall bladder __Appendectomy
__Laparopscopy __Endometrial ablation __Bowel surgery
__Hysterectomy, Type (Abdominal, Vaginal, Laparoscopic) Reason_____
Were ovaries removed? Y N
__OTHER (explain)_____

SOCIAL HISTORY: Do you: __Smoke (how much/day_____) __Drink alcohol (how much/day_____) How much caffeine do you drink/day?____. Are you currently or have you been a victim of abuse? Circle YES NO
Verbal Physical Sexual By whom?_____

FAMILY HISTORY (check if any blood relative has had any of the following and list who had it)

__Heart disease_____ __Breast cancer_____ __Mental retardation_____
__Stroke_____ __Colon cancer_____ __Birth defects/Genetics_____
__Diabetes_____ __Ovarian cancer_____ __Osteoporosis_____
__High blood pressure_____ __Uterine cancer_____ Blood clots(legs/lungs)_____
__Von Willebrands/Hemophilia_____ __Other cancers(type)_____

OBSTETRICAL HISTORY:
Pregnancies:_ Term:_ Preterm:_ Abortions:_ Miscarriages:_ Tubal pregnancies:_ Living:_ Twins:_

Date	Weeks Delivered	Hours of labor	Sex	Weight	Vaginal or C section	Complications?	Where/ who?

Are there any birth defects or genetic illness in you, your partner, or either family?_____

GYNE HISTORY:

Menstrual periods:
Age 1st period_____
Last period_____
How far apart_____
Days of bleeding___
Are they regular? Y N
Severe cramps? Y N
PMS? Y N What?_____
Age at menopause____
Menopause symptoms? Y N
What)_____

STDs:
Any STDs_____
What_____
Treatment_____
Have you had HPV? Y N
HPV vaccine? Y N
Sexually active? Y N
Age 1st intercourse____
# of sex partners_____
Is current partner M or F?

Tests:
Date of last pap_____
Any abnormal paps_____
What was done_____
Date of last mammo_____
Any abnormal mammos? Y N
What was done?_____
Give self breast exams? Y N
Last bone density scan_____
Results_____ treatment_____
Last colonoscopy_____
Results_____

Contraception: (circle) Pill, Patch, Nuva Ring, Shot, IUD(mirena, paragard), Implanon, Diaphragm, Condoms, Spermicide, Natural family planning, Tubal, Vasectomy, Not sexually active, Planning pregnancy, None.

REASON FOR TODAYS VISIT: (please circle any that apply): Routine annual exam and pap, Vaginal discharge, Vaginal irritation, Bleeding problems, PMS, Menopause symptoms, Bladder problems, Bowel problems, Contraception, Pregnancy, Infertility.
Other(explain)_____
Other comments about your health:_____

Signature:_____ Date:_____

HEREDITARY CANCER QUESTIONNAIRE

Patient Name	AGE:

Cancer Type	Who In Family Had It?	Age When Diagnosed
Breast Cancer (Female or Male)		
Ovarian Cancer (Peritoneal/Fallopian Tube)		
Uterine (Endometrial) Cancer		
Colon/Rectal Cancer		
10 or More Lifetime Colon Polyps (Show #)		
Are There Any Other Cancers You Think We Should Know About?		

☐ Yes ☐ No Have you or anyone in your family had genetic testing for a Hereditary Cancer Syndrome with a test called BRCA or Colaris? Who had the test?

Patient's Signature: **Date:**

Doctor's Signature: **Date:**

HERITAGE VALLEY HEALTH SYSTEM

CORPORATE COMPLIANCE PROGRAM

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

PLEASE CHECK ALL THAT APPLY

_____I give permission for my medical information to be left on an answering machine.

_____I give permission for my medical information to be given to/or discussed with: (please write their first and last name)

_____No one other than myself

_____Spouse_____

_____Mother_____

_____Father_____

_____Children_____

_____Caregiver_____

_____Other_____

I acknowledge that this will be considered valid unless revoked by me in writing.

_____ D.O.B._____

Patient Name (please print)

_____ Date:_____

Patient Signature