Washington University in St. Louis
Physicians

*Welcome!*

# Department of Obstetrics and Gynecology
# Gynecologic Questionnaire

Name ______________________________

Date of Birth____________________ Age____ Height ______ feet ______ inches Weight __________ pounds

Occupation ______________________________

## WHAT IS YOUR RACE/ETHNICITY

- ☐ African American
- ☐ Ashkenazi Jewish
- ☐ Asian
- ☐ Asian Indian
- ☐ Caribbean
- ☐ French Canadian
- ☐ Latino/Hispanic
- ☐ Mediterranean (Italian, Greek, Yugoslav, etc.)
- ☐ Middle Eastern
- ☐ Northern European (England, Ireland, Germany, etc.)
- ☐ South Pacific Islander

## WHAT IS THE HIGHEST LEVEL OF SCHOOL THAT YOU REACHED

- ☐ Elementary School
- ☐ Some High School
- ☐ High School Diploma or GED
- ☐ Some college or AA degree
- ☐ College Graduate
- ☐ Graduate degree or higher

## INFORMATION ABOUT PRIOR PREGNANCIES

Do you have infertility? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you been pregnant? ______________________

How many children have you had that were **full term** (delivered at 37 weeks or more)? ______________________

Number of full term children that are still living ______________________

Number of full term children that are deceased ______________________

How many children have you had that were **pre-term** (delivered before 37 weeks)? ______________________

Number of pre-term children that are still living ______________________

Number of pre-term children that are deceased ______________________

How many miscarriages/pregnancy losses have you had? ______________________

☐ Before 14 weeks ☐ 15 - 23 weeks
☐ 24 - 36 weeks ☐ Greater than 37 weeks

How many elective abortions have you had? ______________________

☐ Less than 14 weeks ☐ Greater than 14 weeks

How many tubal or ectopic pregnancies have you had? ______________________

## MENSTRUAL HISTORY

What was the first day of your last normal menstrual period? ______________________

In the prior six months, on average, how many days apart were your periods (from first day to first day)___________

How many days do your periods last? ______________________

In the prior six months, your bleeding was:

☐ Normal ☐ Light ☐ Heavy ☐ Irregular

Are you menopausal? ☐ Yes ☐ No

## CONTRACEPTION

Are you using any form(s) of birth control? ☐ Yes ☐ No If yes, please mark all that apply:

- ☐ Birth Control Pills
- ☐ Condom
- ☐ Diaphragm
- ☐ Depo-Provera
- ☐ Essure
- ☐ Foam
- ☐ IUD
- ☐ Rhythm
- ☐ Sponge
- ☐ Tubal ligation
- ☐ Vasectomy
- ☐ Not sexually active– not having sex with a man
- ☐ Other ______________________

Do you or your doctor think you might be pregnant? ☐ Yes ☐ No

Have you had a pregnancy test? ☐ Yes ☐ No If yes: ☐ Urine ☐ Blood

If yes: ☐ Positive ☐ Negative

## PAST HISTORY

Have you ever had abdominal or vaginal surgery? ☐ Yes ☐ No If yes, please mark all that apply:

- ☐ Abdominal hysterectomy
- ☐ Vaginal hysterectomy
- ☐ Ovary removed – right
- ☐ Ovary removed – left
- ☐ Tubal ligation (tubes tied)
- ☐ Diagnostic laparoscopy
- ☐ D & C
- ☐ Ovarian cyst(s) removed
- ☐ C-section
- ☐ Tubal pregnancy
- ☐ Other – please explain ______________________

Have you ever been told there may be something wrong with your female organs? ☐ Yes ☐ No If yes, please mark all that apply:

- ☐ Cancer – cervix
- ☐ Cancer – uterus
- ☐ Cancer – ovary
- ☐ Cancer – breast
- ☐ Cyst(s) on ovary – right
- ☐ Cyst(s) on ovary – left
- ☐ Endometriosis
- ☐ Fibroid tumor
- ☐ Infection of the tubes
- ☐ Pelvic infection
- ☐ Other ______________________

Do you have any medical problems that require regular trips to the doctor? ☐ Yes ☐ No If yes, please explain:

______________________

______________________

## MEDICATIONS

Do you take any female hormones? ☐ Yes ☐ No If yes– how much ____________

how often ____________

Please list any medications you are taking.

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Do you have any allergies to latex? ☐ Yes ☐ No

Do you have any allergies to iodine? ☐ Yes ☐ No