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

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.
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