Freyja Medical Clinic
570 Price Av., Suite 100, Redwood City, CA
Tel (650) 701.1882 Fax (650) 701.1886
www.Freyjaclinic.com

Gynecology Questionnaire

Please complete and bring this questionnaire with you to your first visit.

MEDICAL ALLERGIES

Which drugs or medicines are you allergic or sensitive to?

Drug	Reaction

Would you like to be screened for sexually transmitted diseases (STD's)? ☐ Yes ☐ No

Do you want to go over the breast exam? ☐ Yes ☐ No

Do you have any present health concerns or anything you want to discuss? ☐ Yes ☐ No

If yes: _____

PATIENT INFORMATION

Name:_____

Address:_____

Phone: Day (___) ____- _____ Evening (___) ____- _____ Cell (___) ____- _____

Age: ____ Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) ____- _____

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name of Spouse/Significant Other: _____
Age: _____

Phone numbers: Day (___) ____- _____ Evening (___) ____- _____ Cell (___) ____- _____

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

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GYNECOLOGICAL HISTORY

How old were you when you had your first period? _____

How frequently do your periods come? Every ____days

How long do your periods last? _____days

When did your last period start? _____

Do you experience cramping with your periods? ☐ Yes ☐ No

If yes, when during your cycles do you have pain (check all that apply):

☐ Before ☐ During ☐ After

How would you describe the cramps? ☐ Mild ☐ Moderate ☐ Severe

Do you take often take pain medication for the cramps? ☐ Yes ☐ No

If yes, specify: _____

Do you bleed or spot between periods? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever had an abnormal Pap smear result? ☐ Yes ☐ No

If yes, what therapy was required?

☐ Cryotherapy (freezing of cervix) ☐ Laser therapy ☐ Cone biopsy ☐ LEEP ☐ Other: _____

Have you ever had an infection involving the reproductive tract?

(Vagina, Cervix, Uterus, Ovaries)? ☐ Yes ☐ No

If yes, which one(s) of the ones below:

☐ Chlamydia ☐ Trichomonas ☐ Gonorrhea ☐ Herpes ☐ Genital warts

What treatment did you receive? _____

Your Current sex partner(s) is/are: ☐ Male ☐ Female ☐ None

Do you have concerns with your sexuality? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Never ☐ Sometimes ☐ Frequently ☐ Always

If yes, does the pain remain in your lower abdomen after intercourse is over? ☐ Yes ☐ No

If yes, how many minutes does It last? _____

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If you are trying to conceive please answer the following questions:

How frequently do you and your partner have intercourse? _____ Per ☐ week ☐ month

How frequently do you and your partner have intercourse around ovulation? ____ each month

Do you usually use lubrication during intercourse? ☐ Yes ☐ No

If yes, please specify type:_____

What type of contraception do you use presently (if applicable)?

☐ Contraceptive pills ☐ Condoms ☐ IUD ☐ Foam/Sponge ☐ Rhythm Withdrawal

Other:_____

What type of contraception have you used in the past (if applicable)?

☐ Contraceptive pills ☐ Condoms ☐ IUD ☐ Foam/Sponge ☐ Rhythm ☐ Withdrawal

Other: _____

Do you know if your mother took DES when she was pregnant with you? ☐ Yes ☐ No

Do you have any family members who have or who have had one of the following Ob/Gyn problems:

☐ Endometriosis ☐ Breast Cancer ☐ Ovarian cancer ☐ Uterine cancer ☐ Cervical cancer

If yes, please specify: _____

OBSTETRICAL HISTORY

Have you ever been pregnant? (Including elective terminations, miscarriages, and births)? ☐ Yes ☐ No

Date:_____

Outcome: _____

How long to conceive: _____

Did you have infertility treatment? _____

Any pregnancy complications?_____

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Past Medical History

Indicate whether you have had any of the following medical problems, with dates:

Alcoholism: _____ Heart disease/Heart attack: _____

High blood pressure: _____ Depression: _____

High Cholesterol: _____ Stroke: _____

Thyroid problem: _____ Diabetes: _____

Cancer (specify what type): _____

Blood transfusions (specify when): _____

Hepatitis (specify type): _____

Other Medical problems (specify) :_____

Surgeries in the past (specify type and date): (1) _____

(2) _____ (3) _____ (4) _____

Family History

Is there any family history of the following? (If so, please indicate who had the condition):

Alcoholism: _____ Heart disease/Heart attack: _____ High blood pressure: _____

Depression: _____ High Cholesterol:: _____ Stroke _____

Thyroid problem: _____ Diabetes :_____

Cancer: Melanoma _____ Breast_____Colon _____

Prostate: _____ Uterus: _____ Cervix: _____

Ovary :_____ other types of Cancers: _____

Blood transfusions (specify when): _____ Hepatitis :_____

Other Medical problems (specify): _____

Social History

Birth place: _____ Education: _____

Occupation:_____

Relationship/ Marital status: _____ Number of children (if any) and what age: _____

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Who lives at home with you? _____

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Review of Symptoms

Do you any recent problems with any of the following? (Please circle all that apply):

Endocrine: fevers/chills/sweats, unexplained weight loss/gain, Change in energy,

Excessive thirst or urination

Eyes: Change in vision

Ears/nose/Throat: Difficult hearing/ringing in ears, teeth or gum problems

Respiratory: Cough, wheeze/shortness of breath

Breast/Chest: Breast lump/nipple discharge

Gastrointestinal: Abdominal pain, blood in bowel movement, nausea/vomiting/diarrhea

Cardiovascular : Chest pain, discomfort, leg pain with exercises/palpitations

Genito/urinary : nighttime urination, leaking urine

Neurological : headache, dizziness/light headedness, numbness, memory loss

Musculoskeletal : Muscle/joint pain, loss of coordination

Allergy: hay fever/allergy

Skin: skin sore, rash, change in mole

Psychiatric: anxiety/stress, problems with sleep, depression Blood: easy bruising/bleeding

Habits

Do you drink alcohol? ☐ Yes ☐ No Drinks/week _____

Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Do you use alcohol now? ☐ Yes ☐ No cigarettes/day _____ for how long? _____yrs

Are you interested in quitting? ☐ Yes ☐ No

Did you use tobacco in the past? ☐ Yes ☐ No cigarettes/day _____

For how long? _____yrs

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When did you quit? _____

Do you or did you use any recreational drugs?

☐ Yes ☐ No _____

Medications

What current prescription and non-prescription medication are you now taking?

Please include dose: Do you need a refill for any of these medications? ☐ Yes ☐ No

If yes, please specify which one(s), specify dose and include the pharmacy info:

_____

Health Maintenance

Do you exercise regularly ☐ Yes ☐ No if yes, what kind: _____

How long: _____min how often per week :_____times

How would you rate your DIET? ☐ Good ☐ Fair ☐ Poor

Are you satisfied with your weight? ☐ Yes ☐ No

Do you do regular breast exams? ☐ Yes ☐ No

When were the following tests most recently done?

Pap smear _____ Mammogram _____ Cholesterol test _____ Thyroid test _____

Glucose _____DEXA (bone scan) _____

Tetanus booster _____ Flu shot _____ sigmoidoscopy _____ Hepatitis B vaccine _____

TB Skin test (PPD) _____ HIV test _____

Pneumonia vaccine _____Exam by an eye doctor _____ Dental check up _____