Department of Obstetrics & Gynecology
3800 Reservoir Road, NW (3PHC)
Washington, DC 20007-2113
202-444-8531PHONE • 1-800-544-7752 FAX
medstargeorgetown.org

MedStar Health

MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL

Appointment Date _____

Review Date _____

Clinician Signature _____

Patient Questionnaire – Obstetrics & Gynecology

Please answer these questions as completely and as accurately as possible.
All information is kept confidential.

PATIENT INFORMATION

Today's Date_____ /_____ /_____

Last name _____ First _____ Middle_____

Address_____

City_____ State _____ ZIP _____

Date of birth_____/_____/_____ Age _____

Email address _____

Indicate preferred phone (please check):

☐ Home _____ ☐ Mobile _____ ☐ Other _____

Spouse/Partner name _____ Spouse/Contact phone_____

Marital status (check) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living together

What is your preferred pronoun? ☐ He ☐ She ☐ They ☐ Them ☐ Other _____

How would you like to be addressed? _____

ADDITIONAL INFORMATION

Have you been diagnosed with COVID-19? ☐ No ☐ Yes, when? _____

Have you been vaccinated for COVID-19? ☐ No ☐ Yes, when? _____

Do you live with someone who currently has COVID-19? ☐ No ☐ Yes, when?_____

PHARMACY INFORMATION

Preferred Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____

REASON FOR MEDICAL APPOINTMENT

☐ Counseling before pregnancy ☐ Previous pregnancy issues ☐ New pregnancy

☐ Annual exam ☐ Gyn concern ☐ Other/explain _____

_____

REFERRING HEALTHCARE PROVIDER

Provider's last name_____ Provider's first name_____

Address_____

City_____ State _____ ZIP _____

Provider's office phone number_____ Office fax number_____

LIST ANY ALLERGIES

☐ None ☐ Yes, explain below

Allergy to what?	Reaction	Allergy to what?	Reaction

Name (print) _____ Date _____

SOCIAL HISTORY

Highest education _____ Occupation _____

Do you follow a special diet? ☐ No ☐ Yes, explain _____

Do you smoke cigarettes? ☐ No ☐ Yes, now ☐ Yes, past Packs/day _____ How many years?_____

Do you smoke e-cigarettes? ☐ No ☐ Yes, now ☐ Yes, past # Per day_____ How many years?_____

Do you drink alcohol? ☐ No ☐ Yes, now ☐ Yes, past # Drinks/wk _____ Type? _____

Do you use marijuana? ☐ No ☐ Yes, now ☐ Yes, past # Time/wk_____ What form?_____

Do you use drugs? ☐ No ☐ Yes, now ☐ Yes, past How often? _____

If yes, what drugs? _____

How many hours of physical exercise do you do per week? _____ Type of exercise _____

_____

Do you feel safe at home? ☐ Yes ☐ No, explain _____

_____

Have you ever been physically abused previously? ☐ No ☐ Yes, explain _____

_____

Have you ever been sexually abused previously? ☐ No ☐ Yes, explain _____

_____

Are you currently being physically or sexually abused? ☐ No ☐ Yes, explain _____

_____

MEDICAL PROBLEMS (Please list)

_____

_____

_____

_____

_____

MEDICATIONS (Include vitamins, natural medications, and over-the-counter medications)

Medication	Dosage	Currently Taking	Not Taking
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

SURGICAL HISTORY ☐ None ☐ Yes, explain

Surgery	Date	Location	Complications / Misc
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name (print) _____ Date _____

GYNECOLOGICAL HISTORY

Date of last normal period _____ Age when periods began _____ years old

How many days in between periods? _____ How many days do your periods last? _____

Any concerns with your periods? ☐ None ☐ Yes, explain _____

Date of last Pap smear _____ ☐ Normal ☐ Abnormal, explain _____

Treatment for abnormal Pap smear? ☐ None ☐ I don't know

☐ Yes: ☐ Repeat Pap smear ☐ Colposcopy ☐ LEEP

☐ Cone biopsy ☐ Freezing

Date of last mammogram _____ ☐ N/A ☐ Normal ☐ Abnormal, explain _____

Previous breast biopsy? ☐ No ☐ Yes, explain _____

☐ Right ☐ Left ☐ Both

Date of colonoscopy _____ ☐ N/A ☐ Normal ☐ Abnormal, explain _____

Date of bone density _____ ☐ N/A ☐ Normal ☐ Abnormal, explain _____

Are you currently pregnant? ☐ No ☐ Yes Date of positive pregnancy test _____

Are you breastfeeding? ☐ No ☐ Yes

Are you planning to get pregnant in the next year? ☐ No ☐ Yes

Current birth control ☐ None ☐ Condoms ☐ Pills ☐ IUD ☐ Implant ☐ Injections

☐ Tubes tied ☐ Vasectomy ☐ Rhythm method ☐ Other

Any infertility problems? ☐ No ☐ Yes, explain _____

Past gynecologic surgery? ☐ No ☐ Yes, explain _____

Have you had any of the following? Fibroids: ☐ No ☐ Yes Ovarian cysts: ☐ No ☐ Yes

Endometriosis: ☐ No ☐ Yes Other/explain _____

Are you sexually active? ☐ Yes ☐ Not currently ☐ Never in the past

Number of partners? Currently____ Ever____ Gender of partner(s) _____

History of sexually transmitted diseases? ☐ No ☐ Yes (check all that apply):

☐ HPV (genital warts) ☐ Syphilis ☐ Gonorrhea ☐ Chlamydia

☐ Trichomonas ☐ HIV ☐ Herpes ☐ Partner with genital herpes

Did you receive the Gardasil HPV vaccine? ☐ I don't know ☐ No ☐ Yes

Have you been tested for BRCA (breast cancer genes)? ☐ I don't know ☐ No ☐ Yes, result _____

Other _____

_____

_____

_____

_____

Name (print) _____ Date _____

MEDICAL AND FAMILY HISTORY (Check all that apply)

	Self	Father	Mother	Any Brother	Any Sister	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Any Son	Any Daughter
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pancreatic cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
DVT/PE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other psychiatric	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Explain:											
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Explain:											
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Explain:											

Additional medical or family history _____

_____

Name (print) _____ Date _____

OTHER PERTINENT HISTORY (Check all that apply)

		Date / Other information
Received Hepatitis B vaccine(s)	☐ No ☐ Yes	_____
High risk for Hepatitis B exposure	☐ No ☐ Yes	_____
Received the influenza vaccine this past season	☐ No ☐ Yes	_____
Had the chicken pox (varicella)	☐ No ☐ Yes	_____
Received the chicken pox (varicella) vaccine	☐ No ☐ Yes	_____
Received the measles vaccine	☐ No ☐ Yes	_____
Exposure to cat litter	☐ No ☐ Yes	_____
Occupational exposure to children	☐ No ☐ Yes	_____
Occupational exposure in health care	☐ No ☐ Yes	_____
Exposure to harmful chemicals or substances	☐ No ☐ Yes	_____
Exposure to X-rays or radiation	☐ No ☐ Yes	_____
Travel outside the USA in the past 6 months	☐ No ☐ Yes	_____
Exposure to tuberculosis	☐ No ☐ Yes	_____
Exposure to coronavirus or COVID-19	☐ No ☐ Yes	_____

Other (explain) _____

_____

_____

_____

ANCESTRY/HERITAGE AND FAMILY REPRODUCTIVE HISTORY (Check all that are appropriate)

Ethnicity	You or your family	Biological father or his family for baby (or for planned pregnancy)
African American	☐	☐
Asian	☐	☐
Caucasian	☐	☐
Hispanic	☐	☐
Ashkenazi Jewish	☐	☐
Other:	☐	☐
Other:	☐	☐
Family reproductive history	**You or your family**	**Biological father or his family for baby (or for planned pregnancy)**
Women who had 3 or more miscarriages	☐	☐
Stillborn babies or children who died in infancy	☐	☐

Name (print) _____ Date _____

PREGNANCY HISTORY

Total number of pregnancies_____ Number of living children _____

Pregnancy outcomes:

Deliveries: ____ Normal ____ Vacuum ____ Forceps ____ Cesarean deliveries

____ Miscarriages ____ Elective abortions ____ Ectopic pregnancies ____ Multiples

Have you ever had the following complication(s)?

☐ Hypertension in pregnancy (preeclampsia, eclampsia, HELLP syndrome, gestational hypertension)

☐ Gestational diabetes ☐ Postpartum hemorrhage ☐ Blood transfusion ☐ Postpartum depression

PREGNANCY INFORMATION

1 - Date	Outcome:	Type of delivery:	Baby sex: ☐ Male ☐ Female	Anesthesia:
	Weeks:	Place of delivery:	Baby weight:	Complications:
2 - Date	Outcome:	Type of delivery:	Baby sex: ☐ Male ☐ Female	Anesthesia:
	Weeks:	Place of delivery:	Baby weight:	Complications:
3 - Date	Outcome:	Type of delivery:	Baby sex: ☐ Male ☐ Female	Anesthesia:
	Weeks:	Place of delivery:	Baby weight:	Complications:
4 - Date	Outcome:	Type of delivery:	Baby sex: ☐ Male ☐ Female	Anesthesia:
	Weeks:	Place of delivery:	Baby weight:	Complications:
5 - Date	Outcome:	Type of delivery:	Baby sex: ☐ Male ☐ Female	Anesthesia:
	Weeks:	Place of delivery:	Baby weight:	Complications:

ADDITIONAL PREGNANCIES AND ANY OTHER INFORMATION

_____

_____

REVIEW OF SYSTEMS Are you experiencing any of the following today?

General Health ☐ Easily fatigued ☐ Involuntary weight gain or loss ☐ Fevers ☐ Other _____

Breast ☐ Breast lump ☐ Nipple discharge ☐ Breast pain ☐ Other _____

Genitourinary ☐ Pelvic pain ☐ Painful urination ☐ Genital sores ☐ Abnormal vaginal bleeding ☐ Vaginal discharge ☐ Other _____

Gastrointestinal ☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Other _____

Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Swelling in legs or feet ☐ Other _____

Pulmonary ☐ Trouble breathing at rest ☐ Cough ☐ Wheezing ☐ Other _____

Neurological ☐ Headaches ☐ Numbness/Tingling ☐ Blurry vision ☐ Other _____

Hematological ☐ Anemia ☐ Easy bruising ☐ Blood clots in leg or lungs ☐ Other _____

Endocrinological ☐ Feeling cold ☐ Feeling hot ☐ Other _____

Mental Health ☐ Depression ☐ Anxiety ☐ Thoughts of harming self or others ☐ Other _____

Dermatological ☐ Change in moles ☐ Rash ☐ Suspicious lesion ☐ Other _____

Thank you for completing this form; please send it via fax 1-877-544-7752 or through the Patient Portal.