Date_____

DRS' EIN, NORMAN, COATES, DEQUATTRO, KHOURY, KLEIN, MUNSON
LEWIS, PAC AND CNMS' BENNETT AND KNOLL
GYNECOLOGICAL / OBSTETRICAL QUESTIONNAIRE

Patient Name_____ Age_____ Date of Birth_____
Chief Complaint_____

ALLERGIES

Name of Drug	Reaction

MEDICATIONS

Name of Drug	

PAST OBSTETRICAL HISTORY

Full Term_____ Premature_____ Abortions/Miscarriages_____ Ectopic_____ Living Children_____

No.	Date	Sex	WT.	Duration of Pregnancy	Duration of Labor	Type of Delivery	Anesthesia	Complications

GYNECOLOGICAL HISTORY

Last Menstrual Period_____ Last Pap Smear_____ Last Mammogram_____ Last Dexa Scan_____

Age began menstrual period_____ Cycle frequency_____ Duration (# of days)_____ Type of birth control_____

MEDICAL HISTORY

1. Diabetes	Yes	No	8. Depression/postpartum	Yes	No
2. Hypertension	Yes	No	9. Hepatitis/liver disease	Yes	No
3. Heart Disease	Yes	No	10. Varicosities/phlebitis	Yes	No
4. Autoimmune Disorder	Yes	No	11. Thyroid dysfunction	Yes	No
5. Kidney Disease/UTI	Yes	No	12. Trauma/violence	Yes	No
6. Neurologic/epilepsy	Yes	No	13. Blood transfusions	Yes	No
7. Psychiatric	Yes	No	14. D (Rh) sensitive	Yes	No

Patient Name_____ Date_____

15. Varicella (chicken pox)	Yes	No	22. Anesthetic complications	Yes	No
16. Pulmonary (TB, Asthma)	Yes	No	23. History of abnormal PAP	Yes	No
17. Seasonal allergies	Yes	No	24. Uterine/Ovarian Anomaly	Yes	No