GYN Questionnaire **Today's Date**_____

Name _____ **Signature**_____
Date of Birth_____

All patients please circle / complete the following questionnaire:

1. Are you currently having a problem you would like to discuss at today's visit? **Y / N**
If yes, please specify:

_____
_____
_____

2. Are you having a problem with any of the following?

Please circle / complete:

Constitution
Unexplained Weight Loss **Y / N**
Unexplained Weight Gain **Y / N**
Fever **Y / N**
Fatigue **Y / N**

Respiratory
Wheezing **Y / N**
Spitting up Blood **Y / N**
Shortness of Breath **Y / N**
Chronic Cough **Y / N**

Psychiatric
Depression **Y / N**
Frequent Crying **Y / N**
Other **Y / N**

Other / Comments:
_____
_____

Musculoskeletal
Muscular Weakness **Y / N**
Joint Pain **Y / N**

Skin / Breast
Breast Pain **Y / N**
Nipple Discharge **Y / N**
Masses **Y / N**
Rash **Y / N**

Genitourinary
Blood in urine **Y / N**
Painful urination **Y / N**
Frequent urination **Y / N**
Incomplete emptying **Y / N**
Painful intercourse **Y / N**
Abnormal periods **Y / N**
Loss of Urine **Y / N**

Lymph
Easily Bruises **Y / N**
Non-Healing Wound **Y / N**

Gastrointestinal
Frequent Diarrhea **Y / N**
Bloody Stool **Y / N**
Nausea / Vomiting **Y / N**
Constipation **Y / N**
Abdominal Bloating **Y / N**

Cardiovascular
Difficulty breathing **Y / N**
Chest Pain **Y / N**
Swelling of Legs **Y / N**
Palpitations **Y / N**

Endocrine
Unusually dry skin **Y / N**
Abnormal thirst **Y / N**

3. Has there been any significant change in your medical history since your last visit? **Y / N**
If yes, please specify: _____
_____
_____

4. Has there been any significant change in your social history (Marital status, Education, Job Change, etc.) since your last visit? **Y / N**
If yes, please specify:

_____
_____

5. Are you currently smoking cigarettes? **Y / N** If so how many per day?_____

6. **6.** Do you regularly drink more than one alcoholic beverage per day? **Y / N**

7. Please list all medications (Prescription and Non-prescription) you are currently taking:

_____
_____
_____

8. Is there any new significant change in your family medical history? **Y / N**
If yes, please specify:

_____
_____

9. Have you developed any new allergies to medications since you last visit? **Y / N**
If yes, please specify: _____
_____