ObGyn of East Brunswick
By Women For Women
an Axia Women's Health Care Center

GYN ANNUAL VISIT QUESTIONAIRE DATE_____

NAME_____ DATE OF BIRTH_____

1. Are you currently having a problem you would like to discuss at today's visit? YES □ NO □

If yes, please specify:_____

2. First day of your last menstrual period_____ How often do you get your menses? Every ____days/menopausal □
How long do your menses last? _____days Are your menses light □ medium□ heavy□ ?
Do you get menstrual cramps? YES □ NO □

3. Are you having a current problem? ALL NO □

Constitution			Genital/Urinary	
Changes in weight	Y/N		Painful intercourse	Y/N
Fever	Y/N		Pelvic pain	Y/N
Fatigue	Y/N		Vaginal dryness	Y/N
			Vaginal itching/burning	Y/N
Endocrine			Vaginal discharge	Y/N
Excessive sweating	Y/N		Painful urination	Y/N
Thyroid problems	Y/N		Frequent urination	Y/N
Abnormal thirst	Y/N		Loss of urine	Y/N
			Lower back pain	Y/N
Respiratory				
Shortness of breath at rest	Y/N		Musculoskeletal	
Shortness of breath with exertion	Y/N		Joint pain	Y/N
			Joint stiffness	Y/N
Breast				
Breast pain	Y/N		Skin	
Nipple discharge	Y/N		Rash	Y/N
Breast lump	Y/N		Lesions	Y/N
Cardiovascular			Neurologic	
Chest pain	Y/N		Headaches	Y/N
			Seizures	Y/N
Gastrointestinal			Fainting	Y/N
Changes in bowel habits	Y/N		Tingling/numbness	Y/N
Abdominal bloating/pain	Y/N			

Psychiatric				
Depression	Y/N			
Frequent crying	Y/N			
Anxiety/panic attacks	Y/N			

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Name_____ DOB_____

OTHER COMMENTS_____

_____

4. Have you had any new medical problems since your last visit? YES □ NO □

If yes, please specify:_____

5. Have you had surgery or been in the hospital since your last visit? YES □ NO □

If yes, please specify:_____

6. Have there been any new life events since your last visit? YES □ NO □

If yes, please specify:_____

7. Has there been any change in your family medical history (parents, siblings, etc.)? YES □ NO □

If yes, please specify:_____

8. Are you currently smoking cigarettes? YES □ NO □ If yes, how many per day? _____Prior smoker? YES □ NO □

9. How many alcoholic beverages do you drink per day? _____ per week? _____

10. Do you use any recreational drugs or prescription drugs not prescribed for you? YES □ NO □

11. Have you been physically or sexually abused? YES □ NO □

12. Do you have any allergies? YES □ NO □

If yes, please specify:_____

13. Sexually active? YES □ NO □ New partners? YES □ NO □ Protection method_____

14. Please list all medications you are currently taking - prescription and non-prescription. Include vitamins, supplements and birth control._____

_____

_____

_____

I confirm that my responses above are accurate to the best of my knowledge.

_____
Signature