Yitzhack Asulin, M.D.
Obstetrics and Gynecology

Comprehensive Health Questionnaire

Please complete the following questionnaire so we can more asses your needs. We realize this health history is quite lengthy, but its comprehensive nature will provide us with a fairly complete summery of your relevant medical history. If you have any difficulty in understanding or answering any of the questions, we will be happy to assist you with completing this form.

Please complete ALL items.

Name: ________________________ Today's Date: ____________________

I would like to be addressed as: ______________ Birth Date: ____________________

Primary Care Provider and others who provide me with care: Dr.____________________

Adress__________________________Phone:______________________

I am here today because: ____

____

Allergies

❒**Medication Allergy:**

____❒Latex ❒Yeast ❒ Eggs

Medications

Medications/Vitamins/Supplements	Dose	Frequency

Gynecological History

Menstrual History

Last Menstrual Period ____________________

Age menses began:________ Num. of days between menses________ Duration ________

Amount: ❒ light ❒ Moderate ❒Heavy

Menstrual symptoms: ❒ Mild ❒severe pain ❒bloating

❒ Severe emotional changes ❒nausea/vomiting

Missed cycles: ❒ never ❒rarely ❒occasionally ❒ frequently

Bleeding between menses:❒ never ❒ rarely ❒occasionally ❒frequently

Have you ever had (check all that apply)**:**

❒ Abnormal Pap test ❒ Positive HPV Test (if yes, date ____________) ❒ Genital Herpes

❒ Genital Warts ❒ Chlamydia ❒ Gonorrhea

❒ Trichomonas ❒ Pelvic Inflammatory Disease (PID) ❒ Bacterial Vaginosis

❒ Yeast Infection ❒ Other STD (specify______________________) ❒ Endometriosis

❒ Fibroids ❒ Pelvic or Abdominal surgery ❒ Fertility problems

❒ Osteopenia / osteoporosis ❒ vaginal dryness ❒ Pelvic pain / pressure

❒ Urinary leakage spontaneously ❒ Urinary leakage when coughing or sneezing ❒ Frequent UTI's

❒ Breast Problems or Surgery ❒ Yes ❒ No Do you perform self-breast exam ❒ Fertility problems

❒ Other GYN condition ____

Dates: Gardasil (HPV Vaccine) #1 ____________ #2 ______________ # 3 _______________

Sexual History

Have you ever had vaginal intercourse? ❒ Yes ❒ No

Are you currently sexually active? ❒ Yes ❒ No

Do you experience pain with intercourse? ❒ Yes ❒ No

Health Maintenance screening	**Normal**	**Abnormal**	**Never**
Last Pap smear (date)			
Last Mammogram (date)			
Last Cholesterol (date)			
Last Colonoscopy (date)			
Bone Density Scan (date)			
Last HIV screening (date)			

Social History

❐Single ❐Married ❐ Divorced ❐Widowed ❐Other

Smoker: ❐ Never ❐ Past ❐ Current (Amount ____________________)

Alcohol: ❐ None ❐ Past ❐ Current (No. drinks per week__________)

Recreational Drugs: ❐ None ❐ Past ❐ Current (Amount/drug________________)

Exercise: ❐No ❐ Yes (frequency and type_______________________________)

Pregnancy History

Number of pregnancies? _____; Number of living children? _____; Number of abortions? _____;

List all pregnancies:

Date of Delivery	Place	Weight	Sex	Type of Delivery	Complications

Past Medical / Surgical History

Condition	Self	Family	Clinician's Comments
Cancer	❐	❐	________________
Heart Disease	❐	❐	________________
Stroke	❐	❐	________________
High Blood Pressure	❐	❐	________________
Diabetes	❐	❐	________________
Blood Clots	❐	❐	________________
Varicose/spider veins	❐	❐	________________
Seizures	❐	❐	________________
Migraines	❐	❐	________________

Kidney disease	❒	❒	______________________________
Liver Disease	❒	❒	______________________________
Gallbladder Disease	❒	❒	______________________________
Bleeding/Clotting Prob.	❒	❒	______________________________
Thyroid Problem	❒	❒	______________________________
Elevated Cholesterol	❒	❒	______________________________
Depression	❒	❒	______________________________
Past Surgery	❒	❒	______________________________

Reviewed :______________________________ Date: ____________________