PLEASE COMPLETE FORM IN INK AND RETURN TO OUR OFFICE.

Wayne Women's Clinic, P.A.

OBSTETRICS & GYNECOLOGY

102 Handley Park Court • Goldsboro, NC 27534

(919) 734-3344


Appt. Date______________________ With ______________________________

Date____________

Name ______________________________________________________________

First Middle Last

Date of Birth _______________Social Security #_________________________

Preferred Language________________ Race ___________________________

Home Phone # ________________________ Mobile #____________________

Mailing Address_________________________________ City_______________

State ___________ Zip Code _________________ County ________________

Place of Work_________________________ Job Title ___________________

Work Phone #_______________ Personal E-Mail Address__________________

Who is your family doctor?_______________________________________

Preferred Pharmacy/Location:_____________________________________

How did you hear about Wayne Women's Clinic?_______________________

Insurance Company______________________________________________

Subscriber's Name & DOB_____________________Relationship______________

Marital Status (Check One)

Single______Married_________Widowed________Divorced________Separated________

Spouse's Name__________________________________________________

Spouse's DOB__________ Spouse's Social Security Number_____________________

Emergency Contact:

Name__________________________ Relationship ____________________

Phone #________________________ Cell #_________________________

## Health History Questionnaire

**Preferred pharmacy and location:**

_______________________________________________

**PCP Name:** _______________________________________________
**Address:** _______________________________________________
**City:** ____________________ **State:** ____________ **Zip:** __________
**Phone #:** ____________________

**I do not have a primary care physician or family doctor.**

**Current Medications: (bring to your appointment)**

| | | |
|---|---|---|
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| | | |
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**Immunizations:** (Approx. date received)
Flu Vaccine ____________________
Gardasil Vaccine ____________________
Tdap Vaccine ____________________
Chickenpox Vaccine ____________________
Pneumonia Vaccine ____________________

**Allergies/Reactions:**

| | |
|---|---|
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| | |

**GYN History:**
First day of last menstrual period: ____________________
Date of last mammogram: ____________________
Date of last colonoscopy: ____________________
Date of last bone density (DEXA): ____________________
Date of last pelvic ultrasound: ____________________
Date/where last pap smear obtained: ____________________

HPV test: ______________________________

Have you received the HPV Vaccine (Gardasil)? Yes No

Any history of abnormal pap smears? Yes No

History of cervical dysplasia? Yes No

Are you sexually active? Yes No

Age at first intercourse: __________

Total lifetime partners: __________

Sexual Orientation:(circle one) Heterosexual Homosexual Bi-sexual Transgender

History of Sexually Transmitted Infections? Yes No

Current birth control method: ______________

Age of first menstrual period: ______________

Age of menopause: __________

Post-menopausal hormone use: ______________________________

History of endometriosis: Yes No

History of fibroids: Yes No

History of infertility: Yes No

History of ovarian problems: Yes No

History of PCOS (polycystic ovarian syndrome): Yes No

Medication taken for menses: Yes No

Menstrual cycle length (days): __________

Diethylstilbestrol (DES) exposed daughters of women who took DES during Pregnancy Yes No

Note:____________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Obstetric History:**

| | |
|---|---|
| Total | |
| Full term | |
| Premature | |
| Abortion Induced | |
| Abortion Spontaneous (miscarriage) | |
| Ectopic | |
| Multibirths (twins, triplets, etc) | |
| Living | |

**Past Pregnancies:**

| Date | Gender | Weight | Delivery type | Doctor | Any Pregnancy Problems |
|---|---|---|---|---|---|
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| | | | | | |

**Family History: (Specify maternal and paternal family members.)**

| | |
|---|---|
| Diabetes | Family member: |
| Disorder of thyroid gland | Family member: |
| Endometrial cancer | Family member: |
| Heart disease | Family member: |
| High Cholesterol | Family member: |
| High Blood Pressure | Family member: |
| Skin cancer | Family member: |
| Uterine cancer | Family member: |
| Breast cancer | Family member: |
| Cervical cancer | Family member: |
| Ovarian cancer | Family member: |
| Colon cancer | Family member: |
| Osteoporosis | Family member: |
| Other: | Family member: |

**Social History:**

Smoking Status (circle one)

Never Smoked    Former Smoker    Current Every Day Smoker    Smoke Occasionally

Smoking How much? ________________ Tobacco years of use: _______________

Deaf or serious difficulty hearing? Yes No

Blind or serious difficulty seeing? Yes No

Difficulty concentrating, remembering, or making decisions: Yes No

Difficulty walking or climbing stairs? Yes No

Difficulty dressing or bathing: Yes No

Difficulty doing errands alone? Yes No

**Exercise Level (circle one)**

None Occasional Moderate Heavy

**Diet (circle one)**

Regular Vegetarian Vegan Gluten Free Diabetic Cardiac Carbohydrate

Other ____________________________

**Caffeine Intake (circle one)**

Never Occasional Moderate Heavy

**Alcohol Intake (circle one)**

Never Occasional Moderate Heavy

How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)

______________ .

**Urinary incontinence:** Yes No

If yes, do you wear a pad or explain: ____________________________________________________________

Illicit drugs ________________________________________ If yes, years of use: __________

Country of birth: ____________________________________

Passive smoke exposure: Yes No

Ethnic background: _________________________________

Highest level of education: __________________________

Occupation: _________________________________________

Marital status: ______________________________________

Sexual orientation: __________________________________

Religion: ___________________________________________

Sexually active: Yes No

Number of sexual partners: ______________

Spouse or partners name: ________________________________________

Protected sex: (circle one) Sometimes Always Never

History of domestic violence: Yes No

Are you employed: Yes No If so, Where?______________________________

General stress level:(circle one) Low Moderate High

Occupational Health Risk: ______________________________

Is blood transfusion acceptable in an emergency?: Yes No

Performs monthly self-breast exams?: Yes No

Hobbies/activities: ______________________________

Seat belts used routinely: Yes No

Have you recently traveled to or lived in a zika affected area (last 12 weeks,or currently pregnant?)

Yes No If yes, where? ______________________________

Do you have symptoms associated with zika virus (fever, rash, joint pain or conjunctivitis)

Yes No If yes, how long? ______________________________

**Surgical History:** (List all surgeries with dates)

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| |

**Past Medical History: (Circle any personal medical conditions past or present)**

**Cancer:** Breast Cervical Colon Uterine Lung Vaginal Vulvar Other__________
**Heart Disease:** Arrhythmia Hypertension High Cholesterol Other:__________
**Dermatology:** Acne Eczema Psoriasis Other:__________
**ENT:** Hearing loss Other:__________
**Endocrine:** Diabetes Gestational Diabetes Thyroid problems Osteoporosis Osteopenia
Other:__________
**Eyes:** Vision loss Macular degeneration Other:__________
**Gastrointestinal:** Colon polyps Crohn's disease Ulcerative colitis Gallbladder disease
Hemorrhoids Irritable bowel disease Liver disease/Hepatitis Reflux/Stomach ulcers Vitamin deficiency Other:__________
**Hematology:** Anemia Bleeding disorder Blood clotting disorder Blood transfusion
Pulmonary embolism Other: __________
**Infectious Disease:** Chickenpox Shingles HIV Rheumatic fever Tuberculosis
Other:__________
**Neurology:** Headaches/Migraines Memory loss/Dementia Neuropathy Seizures/Epilepsy
Stroke Other:__________

**Orthopedics:** Chronic back pain Degenerative joint disease Fractures
Other:________________________________________
**Psychiatry:** ADD Anxiety disorder Bipolar disorder Depression Eating disorder
PMS/PMDD Other:________________________________________
**Pulmonary:** Asthma COPD/Emphysema Seasonal allergies/Allergic rhinitis Sleep apnea
Other:________________________________________
**Rheumatology:** Arthritis Autoimmune disease Fibromyalgia/Chronic pain Restless leg syndrome Other:________________________________________
**Urology:** Frequent urinary tract infections Blood in urine Interstitial cystitis Kidney disease/infection Urinary incontinence Other:______________________________
**Weight Management Problems**

**Please note any particular problems, stresses in your life, or anything else you think we should know:**________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

__________________________________________________

**Signature:** ______________________________ **Date:** ____________________