PREMIER OB GYN INITIAL WOMEN'S HEALTH QUESTIONNAIRE

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Name: _____ Date of birth:_____

Reason for today's visit: _____

Date of your last pap smear:_____Date of your last mammogram: _____

Date of your last dexa scan: _____ Date of your last colonoscopy:_____

GYNECOLOGY HISTORY:

Date of 1st day of your last period:_____ or circle applicable: menopause hysterectomy

History of Abnormal pap smears: Yes____ No____History of STD: Yes_____ No_____

Painful or Post intercourse bleeding: Yes____No___

Currently sexually active? No_____Yes_____ Contraception? No_____Yes_____(include tubal sterilization and/or partner's vasectomy_____

PERSONAL AND FAMILY HISTORY OF CANCER: Please list self or which family member: mother, father, sibling, grandparent (maternal or paternal), aunt/uncle (maternal or paternal)

Ovarian cancer yes no _____
Uterine cancer yes no _____
Colon cancer yes no _____
Breast yes no _____

OB HISTORY: Include and miscarriage/ectopic and/or abortions:

Delivery Date	Weeks Pregnant	Vaginal or C-section	Infant weight	Sex	Hospital	Physician