

JAN RYDFORS MD FACOG, ARON SCHUFTAN MD FACOG

401 Warren Street, Suite # 300, Redwood City, CA 94063
650.701.1882
www.rwcdocs.com

Please complete and bring this questionnaire with you to your first visit.

MEDICAL ALLERGIES

Which drugs or medicines are you allergic or sensitive to?

Drug	Reaction

Would you like to be screened for sexually transmitted diseases (STD's)? Yes No

Do you want to go over the breast exam? Yes No

Do you have any present health concerns or anything you want to discuss? Yes No

If yes: _____

PATIENT INFORMATION

Name: _____

Address: _____

Phone: Day (____) ____ - ____ Evening (____) ____ - ____ Cell (____) ____ - ____

Age: ____ Date of Birth: _____

Marital Status: Married Single Widowed Divorced Separated

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) ____ - ____

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name of Spouse/Significant Other: _____

Age: _____

Phone numbers: Day (____) ____ - ____ Evening (____) ____ - ____ Cell (____) ____ - ____

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

GYNECOLOGICAL HISTORY

How old were you when you had your first period? _____

How frequently do your periods come? Every ____ days

How long do your periods last? _____ days

When did your last period start? _____

Do you experience cramping with your periods? Yes No

If yes, when during your cycles do you have pain (check all that apply):

Before During After

How would you describe the cramps? Mild Moderate Severe

Do you often take pain medication for the cramps? Yes No

If yes, specify: _____

Do you bleed or spot between periods? Yes No

If yes, please describe: _____

Have you ever had an abnormal Pap smear result? Yes No

If yes, what therapy was required?

Cryotherapy (freezing of cervix) Laser therapy Cone biopsy LEEP Other: _____

Have you ever had an infection involving the reproductive tract?

(Vagina, Cervix, Uterus, Ovaries)? Yes No

If yes, which one(s) of the ones below:

Chlamydia Trichomonas Gonorrhea Herpes Genital warts

What treatment did you receive? _____

Your Current sex partner(s) is/are: Male Female None

Do you have concerns with your sexuality? Yes No

Do you have pain with intercourse? Never Sometimes Frequently Always

If yes, does the pain remain in your lower abdomen after intercourse is over? Yes No

If yes, how many minutes does it last? _____

If you are trying to conceive please answer the following questions:

How frequently do you and your partner have intercourse? ____ Per week month

How frequently do you and your partner have intercourse around ovulation? ____ each month

Do you usually use lubrication during intercourse? Yes No

If yes, please specify type: _____

What type of contraception do you use presently (if applicable)?

Contraceptive pills Condoms IUD Foam/Sponge Rhythm Withdrawal

Other: _____

What type of contraception have you used in the past (if applicable)?

Contraceptive pills Condoms IUD Foam/Sponge Rhythm Withdrawal

Other: _____

Do you know if your mother took DES when she was pregnant with you? Yes No

Do you have any family members who have or who have had one of the following Ob/Gyn problems:

Endometriosis Breast Cancer Ovarian cancer Uterine cancer Cervical cancer

If yes, please specify: _____

OBSTETRICAL HISTORY

Have you ever been pregnant? (Including elective terminations, miscarriages, and births)? Yes No

Date: _____

Outcome: _____

How long to conceive: _____

Did you have infertility treatment? _____

Any pregnancy complications? _____

Past Medical History

Indicate whether you have had any of the following medical problems, with dates:

Alcoholism: _____ Heart disease/Heart attack: _____

High blood pressure: _____ Depression: _____

High Cholesterol: _____ Stroke: _____

Thyroid problem: _____ Diabetes: _____

Cancer (specify what type): _____

Blood transfusions (specify when): _____

Hepatitis (specify type): _____

Other Medical problems (specify) : _____

Surgeries in the past (specify type and date): (1) _____

(2) _____ (3) _____ (4) _____

Family History

Is there any family history of the following? (If so, please indicate who had the condition):

Alcoholism: _____ Heart disease/Heart attack: _____ High blood pressure: _____

Depression: _____ High Cholesterol: _____ Stroke _____

Thyroid problem: _____ Diabetes : _____

Cancer: Melanoma _____ Breast _____ Colon _____

Prostate: _____ Uterus: _____ Cervix: _____

Ovary : _____ other types of Cancers: _____

Blood transfusions (specify when): _____ Hepatitis : _____

Other Medical problems (specify): _____

Social History

Birth place: _____ Education: _____

Occupation: _____

Relationship/ Marital status: _____ Number of children (if any) and what age: _____

Who lives at home with you? _____

Is violence at home a concern for you? Yes No

Have you ever been abused? Yes No

Review of Symptoms

Do you any recent problems with any of the following? (Please circle all that apply):

Endocrine: fevers/chills/sweats, unexplained weight loss/gain, Change in energy,

Excessive thirst or urination

Eyes: Change in vision

Ears/nose/Throat: Difficult hearing/ringing in ears, teeth or gum problems

Respiratory: Cough, wheeze/shortness of breath

Breast/Chest: Breast lump/nipple discharge

Gastrointestinal: Abdominal pain, blood in bowel movement, nausea/vomiting/diarrhea

Cardiovascular : Chest pain, discomfort, leg pain with exercises/palpitations

Genito/urinary : nighttime urination, leaking urine

Neurological : headache, dizziness/light headedness, numbness, memory loss

Musculoskeletal : Muscle/joint pain, loss of coordination

Allergy: hay fever/allergy

Skin: skin sore, rash, change in mole

Psychiatric: anxiety/stress, problems with sleep, depression Blood: easy bruising/bleeding

Habits

Do you drink alcohol? Yes No Drinks/week _____

Is your alcohol use a concern for you or others? Yes No

Do you use alcohol now? Yes No cigarettes/day _____ for how long? _____yrs

Are you interested in quitting? Yes No

Did you use tobacco in the past? Yes No cigarettes/day _____

For how long? _____yrs

When did you quit? _____

Do you or did you use any recreational drugs?

Yes No _____

Medications

What current prescription and non-prescription medication are you now taking?

Please include dose: Do you need a refill for any of these medications? Yes No

If yes, please specify which one(s), specify dose and include the pharmacy info:

Health Maintenance

Do you exercise regularly Yes No if yes, what kind: _____

How long: _____min how often per week : _____times

How would you rate your DIET? Good Fair Poor

Are you satisfied with your weight? Yes No

Do you do regular breast exams? Yes No

When were the following tests most recently done?

Pap smear _____ Mammogram _____ Cholesterol test _____ Thyroid test _____

Glucose _____DEXA (bone scan) _____

Tetanus booster _____ Flu shot _____ sigmoidoscopy _____ Hepatitis B vaccine _____

TB Skin test (PPD) _____ HIV test _____

Pneumonia vaccine _____ Exam by an eye doctor _____ Dental check up _____