

OB-GYN & Midwifery Associates of Ithaca
20 Arrowwood Drive, Ithaca, New York 14850
607-266-7800

Please complete this questionnaire prior to your appointment. If you are a new patient, please complete entire form. If you are an established patient, please update as needed. Thank you!

Date: _____

Name: _____ Date of birth: _____ Age: _____

Reason for visit: _____

Menstrual and sexual history

Last menstrual cycle:	Was it a normal period?	Y	N
If menopausal, age at menopause:	Any menopausal symptoms?		
Age at first period:	If under 21, age at first sexual intercourse:		
Number of days between cycles:	Number of days of bleeding:		
Are you currently sexually active?	If yes, with men, women, or both?		
Current birth control method:	Any concerns with your birth control?	Y	N
When was your last pap?	Have you ever have an abnormal pap?		
Have you ever had a colposcopy?	Have you ever had a procedure done to your cervix?		

Have you ever had:	<input type="checkbox"/>	chlamydia	<input type="checkbox"/>	herpes	<input type="checkbox"/>	genital warts
	<input type="checkbox"/>	hepatitis	<input type="checkbox"/>	HIV	<input type="checkbox"/>	syphilis
Have you ever had:	<input type="checkbox"/>	uterine fibroids	<input type="checkbox"/>	endometriosis	<input type="checkbox"/>	ovarian cysts

Pregnancy history

Please enter all information regarding any previous pregnancies. If you have not been pregnant, skip this section.

Date	Delivery location/provider	Sex/Name	Wt	Vaginal/C-section	Complications?

Date	Miscarriage/abortion	Complications

Medical history

Primary care provider(s): _____

Do you have or have you ever had any of the following?

<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	high cholesterol	<input type="checkbox"/>	blood clots
<input type="checkbox"/>	asthma	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	lung disease	<input type="checkbox"/>	diabetes
<input type="checkbox"/>	stomach ulcers	<input type="checkbox"/>	colitis	<input type="checkbox"/>	gallbladder problems	<input type="checkbox"/>	liver problems
<input type="checkbox"/>	kidney stones	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	bladder infections	<input type="checkbox"/>	urinary incontinence
<input type="checkbox"/>	arthritis	<input type="checkbox"/>	joint problems	<input type="checkbox"/>	back injury/pain	<input type="checkbox"/>	broken bones
<input type="checkbox"/>	seizures	<input type="checkbox"/>	migraine headaches	<input type="checkbox"/>	numbness/tingling	<input type="checkbox"/>	breast lump/pain
<input type="checkbox"/>	depression	<input type="checkbox"/>	mental illness	<input type="checkbox"/>	alcoholism	<input type="checkbox"/>	drug use/abuse
<input type="checkbox"/>	skin cancer	<input type="checkbox"/>	abnormal moles	<input type="checkbox"/>	eczema/psoriasis	<input type="checkbox"/>	anemia
<input type="checkbox"/>	stroke	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	hepatitis	<input type="checkbox"/>	autoimmune problems
<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	cancer	<input type="checkbox"/>	anxiety	<input type="checkbox"/>	blood transfusion

Please list any surgeries you have had in the past:

Date	Type of surgery	Reason for surgery	Any complications?

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Name:		Date of birth:	
List any medications you are currently taking, including vitamins or minerals:			
List any allergies you may have to medications:			
Any latex allergy or sensitivity? Y N			
Family history			
<i>Please list any health conditions that pertain to each biological family member. Please include if they are deceased and what caused their death. If no health problems, state "healthy". If no change from your previous visit, please state "no change".</i>			
Brothers/sisters:		Sons/daughters:	
Mother:		Father:	
Maternal grandmother:		Paternal grandmother:	
Maternal grandfather:		Paternal grandfather:	
Other maternal family members:		Other paternal family members:	
Any other significant family history?			
Social history			
Marital/relationship status:		With whom do you live?	
Highest educational level:		Your occupation:	
Tobacco use? Y N	How much per day?	# years use:	
Alcohol use? Y N	How much per day/week?		
Drug use? Y N	What substances?	How much per day/week?	
Caffeine use? Y N	How much per day/week?	Coffee	Tea Soda/soft drinks
Do you exercise?		If yes, how many times per week?	
Do you follow any specific diet?		If yes, what type of diet?	
Do you take a multivitamin?		Do you eat/drink dairy products?	
Do you have any concerns regarding your relationship and/or your safety?			Y N
Have you ever been punched, kicked, hit, threatened, or forced to have intercourse?			Y N
Screening history			
Have you ever had the following screening tests:			
Mammogram:	Y N	If yes, where and when?	
Colonoscopy:	Y N	If yes, where and when?	
Cholesterol tests:	Y N	If yes, where and when?	
Diabetes tests:	Y N	If yes, where and when?	
Bone density scan:	Y N	If yes, where and when?	
Have you received the following vaccinations:			
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Influenza	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Varicella
		<input type="checkbox"/> HPV (Gardasil)	<input type="checkbox"/> Rubella