Northpointe
Obstetrics & Gynecology, P.C.
Competent, compassionate health care for women.

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Patient Questionnaire

All information is treated as confidential unless you grant permission to release it. Please print your answers.

Name _____ **Date** _____

Birthdate _____ **Marital Status** _____ **Referring Doctor** _____

GYNECOLOGIC HISTORY

	Yes	No	
Are you having regular monthly menstrual periods?			Date of last period:
Are you using a birth control method?			What type?
Are you now on or have you ever taken birth control pills?			
Do you regularly have a Pap smear?			Date of last Pap smear:
Have you ever had a sexually transmitted disease (STD)?			When?
Have you ever had a mammogram?			Date of last mammogram:
Have you ever been pregnant?			How many times?

PREGNANCY HISTORY

(Please list the years of all your pregnancies and their outcomes (e.g. vaginal births, C-sections, miscarriage, ectopic pregnancy, etc.)

Year	Outcome	Complications

PAST AND PRESENT MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Asthma			Gall Stones			Poor Blood Clotting		
Angina			Goiter			Phlebitis		
Anemia			Gonorrhea			Rheumatic Fever		
Chronic Lung Disease			Heart Murmur as Adult			Stroke		
Cirrhosis of the Liver			Heart Attack			Stomach or Duodenal Ulcer		
Colon or bowel trouble			High Blood Pressure			Syphilis		
Diabetes			Hepatitis			Tuberculosis		
Emphysema			Kidney Infection			Thyroid Disease		
Enlarged Heart			Kidney Stones					
Other:								