

Queen Anne Obstetrics and Gynecology, PLLP

Susan M Petcoff, D.O. Lynne A Haspedis, D.O.

Date: _____

Name: _____ Age: _____

Referred by: _____

Reason(s) for visit: _____

Gynecological History

Date or year of your last menstrual period? _____

Age when menses began _____ How many days do you bleed each month? _____

How many days are there from the start of one period to the next? (28-30) _____

Are you sexually active? _____ Current birth control method? _____

Would you like to be tested for STDs? _____

Date of last PAP smear _____ Result _____

Date of last mammogram _____ Result _____

Do you have?

Yes

No

Please explain

Heavy menstrual bleeding? Yes No _____

Painful periods Yes No _____

Irregular periods Yes No _____

Bleeding between periods Yes No _____

Premenstrual difficulties Yes No _____

History of DES exposure Yes No _____

Leakage of urine Yes No _____

Have you ever had?

An abnormal PAP smear Yes No _____

Pelvic infections/STDs Yes No _____

An IUD for birth control Yes No _____

Infertility Yes No _____

Hysterectomy Yes No _____

Breast Biopsy Yes No _____

Hormone replacement Yes No _____

Sexual abuse Yes No _____

HIV testing Yes No _____

Blood transfusion Yes No _____

Allergies

(list all allergies to medicines and reactions)

Medications

(please list all medications and dosages)

Please continue to back of sheet

REVIEWED BY _____

Past medical history (list major illnesses, hospitalizations, high blood pressure, diabetes, etc)

Past surgical history (includes approximate date of each surgery)

Obstetrical history (list all pregnancies, including miscarriages, abortions, and ectopic pregnancies)

Do you? Did you?	Yes	No	Describe
Smoke	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____ When did you quit? _____
Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____ When did you quit? _____
Use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	Type? _____ When did you last use? _____
Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	How often? _____
Perform self breast exam	<input type="checkbox"/>	<input type="checkbox"/>	How often? _____
Any weight change	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____ Since when? _____
Cholesterol level	<input type="checkbox"/>	<input type="checkbox"/>	When? _____ Result? _____
Tetanus vaccine (within last 10 years)	<input type="checkbox"/>	<input type="checkbox"/>	When? _____

Family History (in your family, does anyone have/had the following)

	Yes	No	Which Family Members?
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Your occupation _____

Your partner/spouse's name _____

Any particular stresses or problems? _____

*Thank you for completing this form; it allows us more time to address your concerns.
Please call our office at least 24 hours in advance if you are unable to keep your appointment*

Patient's name _____

Allergies _____

Doctor's Name _____

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