Name: _____ Date: _____

Susie N Chung, MD PA

OFFICE VISIT QUESTIONNAIRE

Reason for your Visit today (please circle): WELL WOMAN VISIT / PROBLEM
During my exam today, I (please circle): DECLINE a chaperone / DESIRE a chaperone

___ **NO GYN problems today!**

GYN PROBLEM(s) you would like to discuss today (please circle):
Any additional time and/or discussion outside the scope of a well woman visit will generate an additional charge to your insurance company.

___ **Abnormal Periods:** No periods / Skipping periods / Bleeding between periods / Painful periods / Bleeding heavily
Extreme Mood changes with periods / Menstrual headaches / Menstrual migraines

___ **Vulvar / Vaginal problems:** Abnormal Discharge / Odor / Itching / Pain / Irritation / Cyst / Ulcer / Lump / Boils
Tissue bulging out of vagina
Want STD check (genital cultures and/or labs)

___ **Pelvic problems:** General Pelvic Pain / Pelvic Pressure / Ovarian Cyst

___ **Urinary symptoms:** Painful urination / Urgency / Frequency / Incontinence / Blood in urine / Incomplete emptying

___ **Problems with sex:** Painful sex / Bleeding after sex / Vaginal Dryness / Decreased Libido

___ **Contraception:** Want to discuss options / Want to change contraception / Need Contraception Refill / IUD string check

___ **Breast symptoms:** Breast pain / Breast lump / Fibrocystic breast disease / Rash / Nipple discharge / Breast feeding

___ **Menopausal symptoms:** Hot Flashes / Night sweats / Difficulty with Memory & Concentration / Moodiness

___ **Infidelity:** Suspect or Known Infidelity by partner / Unfaithful to partner

___ **HPV Vaccination** (<27 y/o are candidates): Want information/ Need 1st shot / Need 2nd shot / Need last shot

___ **Preconception Consultation**

___ **Infertility:** Difficulty getting pregnant / Difficulty staying pregnant / History of IUI, IVF, ovarian stimulation

___ **Pregnancy symptoms:** Bleeding / Breast tenderness / Nausea / Throwing up / Cramping / Constipation

___ **Dermatologic:** Acne / Excessive hair growth on face / Excessive hair growth on chest/ Excessive hair growth on lower belly

___ Other: _____

GYN History: When was the first day of your last period (LMP)? _____ And the period before that (PMP)?_____
How often do you get your period?_____ # of days you bleed:_____
Current Birth Control:_____ Currently Sexually Active: Yes / No New partner in last year: Yes / No
Cumulative # of Male partners til now:_____ Heterosexual / Homosexual / Bisexual **Sexual Activity**: Vaginal / Anal / Oral

OBSTETRIC HISTORY: *(update if anything is new; if nothing to update, please write in "N/A")*

MEDICAL/PSYCHIATRIC HISTORY: *(update if anything is new; if nothing to update, please write "n/a")***:**

SURGICAL History *(update if anything is new; if nothing to update, please write "n/a")***:**

Name: _____ Date: _____

MEDICATIONS: *(list all current medications; prescription, homeopathic and over-the-counter)*

-
-
-
-
-
-

DRUG ALLERGIES: *(list reaction to medication)*

-
-

Update your Family History: 1st or 2nd degree relatives only (parents, children, siblings, aunts, grandparents)

__Depression __Bipolar Disease __Schizophrenia __Alzheimers __Parkinsons ___Stroke
__Hypertension __Diabetes __Heart Attack __Blood Clots (DVT/PE)
__Breast Cancer __Ovarian Cancer __Uterine Cancer __Colorectal Cancer __Stomach Cancer __Kidney/urinary tract Cancer
__Brain Cancer __10 or more colon polyps __Melanoma __Pancreatic Cancer __Other Cancer _____
__Ashkenazi Jewish Descent Have you or your family members test **positive** for Hereditary Risk of Cancer? Yes / No
__Endometriosis __PCOS Any other Pertinent FAMILY history: _____

Social History:

Partner's name:_____Single /Married /Engaged /Separated /Divorced /Widowed /Common Law
Children's names:_____
With Whom do you live?_____ Your Occupation: _____
Diet: No restrictions/Vegetarian/Pescatarian/Gluten-free/Lactose intolerant/Other:_____Caffeine Intake: _____cups per day
Exercise: None / Occasional / Moderate / Heavy; Exercise Type:_____How many times per week?_____
Tobacco: Non-smoker_____; Vapes_____; Quit_____ ; Social smoking_____
____packs/cigs per day; ____# of years smoking; Trying to quit? Yes / No
Alcohol use: Don't drink_____; Drink socially____; Drink regularly_____; Dependence on Alcohol_____; Involved in AA_____
Illegal drugs: Never used drugs____ Past Regular Drug Use: _____ Current Drug Use: _____
Current or History of Verbal Abuse: Yes / No By Whom: _____
Current or History of Physical Abuse: Yes / No By Whom: _____
Current or History of Sexual Abuse: Yes / No By Whom: _____

Review of Systems: Please **CHECK** what is **CURRENTLY** pertinent to you.

General: Fever / Chills / Weight Loss / Weight gain / Fatigue / Loss of Energy / Loss of appetite /Other: _____
Psychiatric: Depression / Anxiety / Irritability / Suicidal ideation / Homicidal ideation /Other: _____
Skin: Rash / Dry Skin / Suspicious Mole / Hair loss / Other: _____
Neurologic: Headaches / Dizziness / Fainting spells / Seizures/ Weakness / Numbness / Other: _____
Endocrine: Cold Intolerance / Heat intolerance /Other: _____
Eyes/ Ears/ Nose/ Mouth/ Throat: Double vision / Visual Disturbance / Hearing Impairment / Oral ulcers /Other: _____
Cardiovascular: Chest pain / Palpitations / Varicose veins / Other: _____
Respiratory: Wheezing / Shortness of breath / Cough / Other: _____
Gastro-intestinal: Abdominal pain / Nausea / Throwing up / Constipation / Diarrhea / Blood in stool / Other: _____
Musculoskeletal: Joint Pain / Bone Fracture / Muscle Aches / Back pain / Leg Cramps / Swelling / Other: _____
Allergy/ Immunology: Seasonal Allergies / Food Allergies / Itching/ Hives / Other: _____
Heme/ Onc/ Lymphatic: Bruise easily / Bleed easily / Chemo or Radiation Therapy / DVT / Other: _____

Update if pertinent:

Date of Last MAMMO: _____ Date of Last Colonoscopy:_____ Date of Last Bone Density (DEXA): _____