SWEDISH
MEDICAL GROUP

OB/GYN & Midwifery New Patient Health History Questionnaire

Preferred name: _____ Legal name: _____

Gender pronouns: ☐ She/her ☐ He/him ☐ They/them ☐ Other: _____

Legal gender designation (on insurance): ☐ Female ☐ Male Self-declared gender: ☐ Female ☐ Male ☐ Other

Marital status: _____ Who do you live with? _____

Would you accept a blood transfusion in an emergency? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

What is your main concern today?:

_____

Personal Past Medical History: What medical problems have you been told you need ongoing care for? (i.e., high blood pressure, diabetes, asthma, heart disease, etc.)

_____

_____

_____

Surgical History: Have you ever had any type of surgery (including dental)?

Surgery/Reason_____ Date_____

Surgery/Reason_____ Date_____

Surgery/Reason_____ Date_____

Surgery/Reason_____ Date_____

Family History: ☐ I am adopted or do not know my family history

Has anyone in your family ever had cancers of the:

Breast ☐ No ☐ Yes Ovary ☐ No ☐ Yes

Colon ☐ No ☐ Yes Endometrium/Uterus ☐ No ☐ Yes

Please list any known major medical conditions for your immediate relatives:

Mother _____ Father _____

Brother _____ Sister _____

Maternal Grandmother _____ Maternal Grandfather _____

Paternal Grandmother _____ Maternal Grandfather _____

Sexual and Reproductive Health History:

Do you have periods? ☐ Yes ☐ No If menopausal, when did your periods stop? _____

Age when you first had a menstrual period: _____ First day of your last menstrual period? _____

Are your periods monthly? ☐ Yes ☐ No

# of days of bleeding? _____ # of days between cycles?: _____

Have you ever been sexually active? ☐ Yes ☐ No Types of sex: ☐ Vaginal ☐ Oral ☐ Anal

Current birth control (if any): _____ Are you happy with this birth control? ☐ Yes ☐ No

Have you or your partner(s) had other sexual partners in the past year? ☐ Yes ☐ No ☐ Unsure

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Partners are/have been: ☐ Male ☐ Female ☐ Nonbinary/Transgender

Do you regularly use condoms/barriers for sex? ☐ Yes ☐ No

Have you ever had a Sexually Transmitted Infection (STI)? ☐ Yes ☐ No

Circle if yes: Genital Herpes, Chlamydia, Gonorrhea, Trichomonas, Syphilis, Genital Warts, HIV

Are you concerned about your risk for STIs/would you like testing? ☐ Yes ☐ No

Did you have the HPV vaccine series? ☐ Yes ☐ No

Date of your last Pap Test? _____ Have you ever had an abnormal Pap or colposcopy?: ☐ Yes ☐ No

Have you ever had a LEEP, cone biopsy, or any other cervical surgery? ☐ Yes - date: _____ ☐ No

Obstetrical History: Please list all your pregnancies, including each outcome (term birth, preterm birth, miscarriage, and/or termination of pregnancy):

☐ N/A (I am not and have never been pregnant)

Date	Weeks pregnant	Delivery type (vaginal or cesarean) (termination or loss)	Weight of infant	Tear into anus or rectum?	Vacuum or forceps?	Pregnancy/Delivery complications? (e.g. Diabetes, pre-eclampsia, hemorrhage, stillbirth)

Social History and Health Habits: (please circle day or week)

Smoking/tobacco _____ cigarettes per day/week If former smoker, when did you quit? _____

Marijuana _____ times per day/week What form?: _____

Alcoholic drinks _____ drinks per day/week

Recreational drugs (including prescription meds) _____ times per day/week

Do you think you have a problem with drugs or alcohol? ☐ Yes ☐ No ☐ Unsure

Safety Questions:

Does anyone hurt, hit, threaten, or scare you, or make you have sex if you do not want to? ☐ Yes ☐ No

PHQ-2

Over the past 2 weeks, how often have you been bothered by any of the following problems? (Please mark the box):

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				