Mercy Clinic Minimally Invasive Gynecology
621 S. New Ballas Rd. | Suite 499A | St. Louis, MO 63141
314-251-7650 | fax 314-251-7651

Richard Gimpelson, MD
David Levine, MD
Corey Wagner, MD

General Health Questionnaire

Name:____________________ DOB: __________ Age: ____ Today's Date: __________

New Patients: Please fill out the entire form to the best of your ability.

Established Patients: Please fill out the sections labeled "Menstrual History" and "Health Screenings."
For all other sections, you may check "No changes" or provide updated information as applicable.

1. **What is the reason for today's visit** *(check all that apply)*: ☐ ____________________

   ☐ Abnormal menstruation/bleeding
   ☐ Annual examination
   ☐ Bladder drop/Prolapse
   ☐ Breast issues
   ☐ Infertility
   ☐ Menopausal concerns
   ☐ Pelvic pain/Endometriosis
   ☐ Urinary problems/Incontinence

2. **Menstrual History**

   a. Are you in menopause? ☐ No ☐ Yes
      i. Have you had any vaginal bleeding since your periods stopped? ☐ No ☐ Yes
      ii. Age at last period? __________
      iii. If you are in menopause, skip to question #3.
   b. Are your periods bothersome? ☐ No ☐ Yes
      i. If so, how long have they been this way? __________
   c. Age at first period (menarchy)? __________
   d. Date of last period (1st day of bleeding)? __________
   e. How often do you have a period?
      (day one to day one, range 25-35 days) __________
   f. Are your cycles irregular (>4 days) and/or unpredictable? ☐ No ☐ Yes
      i. If yes, how many periods do have per year? __________
   g. Total number of days with bleeding (on average)? __________
   h. Number of days with heavy bleeding (on average)? __________
   i. When bleeding is heaviest, how often do you change pads/tampons (how many minutes/hours)? __________
   j. Do you ever have to use "double protection," (meaning both pads and tampons)? ☐ No ☐ Yes
   k. Do you ever bleed onto your clothing? ☐ No ☐ Yes
   l. Do you pass blood clots? (circle one) ☐ No ☐ Yes
      none / dime size / quarter size / larger
   m. Do you have painful cramps during your periods? ☐ No ☐ Yes
      i. Do you take medication for these cramps? ☐ No ☐ Yes
      ii. How many days per month are you unable to go to school or work? __________

Initials/Date: ________________

3. **Health Screenings**

Test	Date	Result	Ever had an Abnormal? When?
Pap Smear			
Mammogram			
STD screening			
Colonoscopy			
Bone density test			

4. **Healthcare Team** ☐ No Changes

a. Who referred you here? ____________________

b. Who is your Primary Care Physician? ____________________

c. Who is your General Gynecologist? ____________________

d. List any other doctors you see (such as cardiologist or endocrinologist) ____________________ ____________________ ____________________

5. **Allergies** ☐ No Known Allergies ☐ No Changes

Medication Name	**Reaction**	**Medication Name**	**Reaction**

6. **Current Medications** ☐ No Medications ☐ No Changes

Name of Medication	**Dose**	**How often taken**

7. **Obstetrical History** *Please list all pregnancies in order* ☐ No Changes

Year	**Gestational Age** (weeks)	**Birth Weight**	**Delivery Type** (vaginal, C-section, forceps, miscarriage)	**Complications** (vaginal laceration/tear/4th degree episiotomy/hemorrhage/meds for bleeding)

8. **Gynecologic History** ☐ No Changes

a. Have you ever been told you have HPV? ☐ No ☐ Yes

b. Have you ever had a sexually transmitted infection? ☐ No ☐ Yes

i. If yes: HIV / Syphilis / Hepatitis / Herpes / Chlamydia / Gonorrhea

c. Have you ever had Pelvic Inflammatory Disease (PID)? ☐ No ☐ Yes

Initials/Date: ____________________________

9. Sexual History ☐ Never sexual (skip to #10) ☐ No Changes

a. Have you had any new sexual partners (past year)? ☐ No ☐ Yes

b. Are you currently abstaining from sexual activity? ☐ No ☐ Yes

i. If yes, list reason (pain, unable to, single, etc.) ____________________

c. How many total sexual partners have you had? ____________________

d. What do you use for contraception? (*Circle all that apply:* coital timing technique, condom, spermicide, oral contraceptive, vaginal ring, diaphragm, Depo Provera, Implanon/Nexplanon, IUD, tubal occlusion, vasectomy, hysterectomy)

Other: ____

e. Sexual preference: (circle) Men / Women / Both

f. Victim of sexual abuse: ☐ No ☐ Yes

10. Medical History *(check all that apply)* ☐ No Problems ☐ No Changes

☐	Abnormal EKG	☐	Diabetes Type II	☐	Kidney Stones
☐	Anemia	☐	Diabetes Controlled	☐	Liver Disease/Hepatitis
☐	Anesthetic Complications	☐	DVT (blood clots)	☐	Migraines
☐	Anticoagulation (thin blood)	☐	Emphysema	☐	Neurologic Disorder
☐	Arthritis	☐	Epilepsy/Seizures	☐	Obesity
☐	Asthma	☐	Fibromyalgia	☐	Osteoporosis/Osteopenia
☐	Atrial Fibrillation	☐	Glaucoma	☐	Pulmonary Embolus
☐	Anxiety/Depression *(circle)*	☐	Heart Attack (MI)	☐	Sickle Cell Disease/Trait
☐	Bladder/Kidney Infections	☐	Heart Burn/GERD	☐	Stroke
☐	Blood Disease	☐	Heart Murmur	☐	Thyroid Disease
☐	Cancer	☐	Herniated Discs	☐	Tuberculosis
☐	Congenital Heart Disease	☐	High Cholesterol	☐	Ulcerative Colitis
☐	Congestive Heart Failure	☐	Hypertension	☐	Von Willebrand's Disease
☐	COPD	☐	Interstitial Cystitis	☐	
☐	Crohn's Disease	☐	Irritable Bowel Syndrome	☐	
☐	Diabetes Type I	☐	Kidney Disease	☐	

List any other medical problems:____

11. Surgical History *(check all that apply and include year of surgery)* ☐ No Surgeries ☐ No Changes

☐	Acessa/Uterine Artery Embolization	☐	Diagnostic Laparoscopy only	☐	Mastectomy
☐	Adhesions Removed	☐	Ectopic Pregnancy	☐	Ovarian Cyst: left/right/both
☐	Appendectomy	☐	Endometriosis Removed	☐	Ovary removed: left/right/both
☐	Back Surgery	☐	Essure/Adiana	☐	Pelvic Reconstruction (no mesh)
☐	Breast Augmentation	☐	Fecal Incontinence	☐	Pelvic Reconstruction with mesh
☐	Bladder	☐	Fibroids Removed	☐	Tonsillectomy
☐	Breast Reduction	☐	Gallbladder Removed	☐	Tubal Ligation
☐	Bowel	☐	Heart Surgery/Stents	☐	Tubes Removed L/R/Both
☐	C-section: How many? #_____	☐	Hernia Repair	☐	Urinary Incontinence
☐	Cervical Biopsy	☐	Hysteroscopy: #________	☐	Uterine Ablation - type? *(circle)* Cyro/HTA/NovaSure/ Resection/ThermaChoice
☐	Cervical Cerclage	☐	Hysterectomy: Abdominal/ Laparoscopic/Vag/Robotic		
☐	Cervical Conization/LEEP				
☐	D&C: How many? #________	☐	IVF	☐	
☐	Diagnostic Hysteroscopy	☐	Laparoscopy: #________	☐	

List any other surgical procedures: ____

Initials/Date: ____________________

12. Family History ☐ No Problems ☐ No Changes

		Family Member	Age at Diagnosis
☐	Breast Cancer/BRCA gene		
☐	Colon Cancer		
☐	DVT/PE (blood clots)		
☐	Endometriosis		
☐	Heart Disease/Stroke		
☐	Hypertension		
☐	Osteoporosis		
☐	Ovarian Cancer		
☐	Uterine Cancer		
☐	Other		

13. Social History ☐ No Changes

a. Marital status: (circle one) **Single / Married / Separated / Divorced / Widowed**

b. Do you drink caffeine? ☐ No ☐ Yes

i. If yes, how many cups per day? ____________________

c. Do you smoke or chew tobacco? ☐ No ☐ Yes

i. If yes, how many packs per day? ____________________

ii. For how many years? ____________________

d. Do you drink alcohol? ☐ No ☐ Yes

i. If yes, how many drinks per week? ____________________

d. Do you use any street drugs? ☐ No ☐ Yes

i. If yes, what types? ____________________

14. Review of Systems: *Circle all that apply or circle "none"* ☐ No Changes

Constitutional	Fever, chills, sweats, fatigue, weight loss	None
Eyes	Visual disturbance, irritation, redness, yellow in eyes	None
Head & neck	Hearing loss, bloody noses, snoring, voice changes	None
Cardiovascular	Chest pain, shortness of breath, palpitations, fainting	None
Respiratory	Cough, wheezing, coughing up blood	None
Gastrointestinal	Nausea, vomiting, change in bowel habits, bloody stool	None
Genitourinary	Frequent urination, painful urination, bloody urine	None
Musculoskeletal	Back pain, muscle pain, joint pain, weakness	None
Integumentary	Rash, skin lesions, itching, changing mole, breast lump, nipple discharge	None
Neurological	Headache, dizziness, seizures, tingling/numbness	None
Psychiatric	Abusive relationship, eating disorder, anxiety, depression	None
Endocrine	Fatigue, weight gain, intolerance to hot or cold	None
Hematologic	Easy bruising, bleeding easily, enlarged lymph nodes	None
Allergic	Rashes, anaphylaxis	None

Signature/Date: ______________________________ Reviewed by: Dr.______________________