Dr. Krishna Kakani
Gynecology
699 Gallatin St SW, Ste B1
Huntsville, AL 35801

Patient History Questionnaire

Name: _____ DOB: _____ Today's Date: _____

General:

1. Marital Status ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widow
2. Reason for Visit: _____
3. Primary Physician: _____
4. Occupation: _____
5. Preferred Phone Number: _____ Confidential voicemails okay? ☐
6. Partner: _____
    a. Partner's Age: _____
    b. Partner's Occupation: _____

Menstrual History:

7. Age of First Period: _____ years old
8. If you have regular periods - periods start every _____ days
9. If you have irregular periods - periods start every _____ to _____ days (ex. 12 to 60 days)
10. Duration of Bleeding: _____ days
11. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally
    a. If yes, is it: ☐ Before Menses ☐ After Menses ☐ Both
12. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
13. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
14. First day of last menstrual period: _____ or ☐ Menopausal

Pregnancy History:

15. Obstetrical History, incl. abortions and ectopic (tubal) pregnancies, or ☐ Never Pregnant

Year	Place of Delivery / Abortion	Pregnancy Duration	Hours of Labor	Type of Delivery	Complications (Mother / Infant)	Child's Sex	Child's Birth Weight	Child's Present Health

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Birth Control History:

16. What birth control method(s) do you currently use?

_____

Sexual History:

17. Do you have a sexual partner? ☐ Yes ☐ No
    a. If yes: ☐ Male ☐ Female
18. Do you have any concerns you'd like to discuss with your provider? ☐ Yes ☐ No

Past Obstetrical/Gynecological Surgeries:

19. Please check any that apply, or ☐ None

	Year		Year
☐ D & C	_____	☐ Ovarian Surgery	_____
☐ Hysteroscopy	_____	☐ L Ovarian Cyst(s) Removed	_____
☐ Infertility Surgery	_____	☐ R Ovarian Cyst(s) Removed	_____
☐ Tuboplasty	_____	☐ L Ovary Removed	_____
☐ Tubal Ligation	_____	☐ R Ovary Removed	_____
☐ Laparoscopy	_____	☐ Vaginal / Bladder Repair for Prolapse or Incontinence	_____
☐ Hysterectomy (vaginal)	_____	☐ Cesarean Section	_____
☐ Hysterectomy (abdominal)	_____	☐ Other (Please Specify): _____	_____
☐ Myomectomy	_____		

Other Past Surgical History (Not OB/GYN-Related):

20. Please list all surgeries and the years they were performed:

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

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Pap Smear/Mammogram History:

21. Date of last pap smear: _____
22. Have you had an abnormal pap smear? ☐ Yes ☐ No
23. Have you had treatment for abnormal pap smear? ☐ Yes ☐ No
    a. If yes, what type(s) of treatment have you had?
    - ☐ Cryotherapy Year _____
    - ☐ Laser Year _____
    - ☐ Cone Biopsy Year _____
    - ☐ Loop Excision (LEEP) Year _____

24. Date of last mammogram: _____
25. Have you had an abnormal mammogram? ☐ Yes ☐ No

Other Gynecological History:

26. Please check any that apply: or ☐ None

- ☐ Venereal Warts
- ☐ Herpes - Genital
- ☐ Syphilis
- ☐ Pelvic Inflammatory Disease
- ☐ Other _____
- ☐ Endometriosis
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Vaginal Infections

Social History:

27. Smoke or Vape ☐ No ☐ Yes (_____ packs/day)
28. Use Alcohol ☐ No ☐ Yes (Wine: _____ glasses/day; Beer: _____ bottles/day)
29. Illicit Drugs ☐ No ☐ Yes (Type: _____ Amount: _____)
30. Exercise: Type: _____ Frequency: _____

Current Medications:

31. Include dose (amount) per day:

Medication	Dose	Frequency

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Preferred Pharmacy:

32. Name: _____ Phone #: _____

Past Medical History:

33. Please check any that apply: or ☐ None

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Diabetes:
  - ☐ Diet Controlled
  - ☐ Pill Controlled
  - ☐ Insulin Controlled
  - ☐ Not Controlled
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ HIV+
- ☐ Kidney Disease
- ☐ Liver Disease (Including hepatitis)
- ☐ Thyroid Disease
- ☐ Other _____

Drug Allergies:

34. Please list any medication allergies: or ☐ None

_____

_____

_____

Family History:

35. Please check any that apply: or ☐ None

	Mother	Father	Maternal G.mother	Maternal G.father	Paternal G.mother	Paternal G.father
☐ Breast Cancer	☐	☐	☐	☐	☐	☐
☐ Cervical Cancer	☐	☐	☐	☐	☐	☐
☐ Colon Cancer	☐	☐	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐	☐
☐ Heart Attack	☐	☐	☐	☐	☐	☐
☐ Heart Disease	☐	☐	☐	☐	☐	☐
☐ Hypertension	☐	☐	☐	☐	☐	☐
☐ Ovarian Cancer	☐	☐	☐	☐	☐	☐
☐ Prostate Cancer	☐	☐	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐	☐	☐
☐ Uterine Cancer	☐	☐	☐	☐	☐	☐