Please complete this patient information survey to the best of your knowledge & ability. Please leave any sections blank if you are unsure or uncomfortable answering, or that do not apply to you. The purpose of these questions is to recognize a holistic range of factors which may affect your care, and to help us identify and meet your individual health needs. This survey will become part of your confidential medical record. Thank you!

Name: _____ **Date of Birth (M/D/Y)**: _____ **Age**: _____

Preferred Pronouns (please circle): She / Her He / Him They / Them

I. MEDICAL HISTORY:

Please list any allergies below (latex, medications, foods, etc.):

_____

_____

Please list all current prescription medications, as well as any vitamins or supplements you use on a regular basis.

_____

_____

Did you have this year's seasonal flu vaccine? **Yes / No**

Have you had the COVID vaccination? **Yes / No.** If you have not would you be interested in getting one? **Yes / NO / Maybe**

Approximate date and location (please specify name of medical office / facility) of your last Pap? (Please write "N/A" if you've never had a Pap)

_____

Approximate date & location (name of medical facility) of last mammogram? (Write "N/A" if you've never had a mammogram)

_____

Do you see another healthcare provider or office for primary care needs / annual exams? **Yes / No**
If Yes, please indicate your PCP and approximate date of last visit.

_____

Please indicate Yes or No if **YOU** have/ have had the following:

	Yes	No		Yes	No
Asthma			Migraines		
Eczema or Psoriasis			GI disease: GERD, IBS, pancreatitis, or IBD (Crohns, colitis)		
Blood Transfusion			Chronic Pain or Fibromyalgia		
Kidney stones			Gallbladder stones or disease		
Genital Herpes			Other STI (chlamydia, gonorrhea, trich, HIV, syphilis) or PID		
Abnormal Pap			If Y, did you have colposcopy, cryotherapy, LEEP, or conization?		

Chickenpox			If N, have you had a varicella vaccine?		

Notes / Details:

Please complete table below: Are **you or your blood relatives** (parents, grandparents, siblings, children, aunts/uncles) affected by any of the following conditions? If so, please check the appropriate column, indicate age at onset of the condition (approximate is fine), and note which relative was affected or any additional details.

☐ Please check here if you are adopted

	Me	Family	Age at Onset	Notes
Thyroid Disease (i.e. Hashimoto, Graves)				
Hypertension (high blood pressure), including preeclampsia				
Diabetes (including gestational diabetes)				
High cholesterol				
Mental Illness (including depression, anxiety, eating disorder, postpartum depression, PTSD)				
Uterine fibroids				
Preterm Delivery (<37 wk)				
Osteoporosis				
Blood Clot (DVT, PE)				
Autoimmune Disease (i.e. lupus, MS, RA)				
Seizures				
Liver Disease (including hepatitis)				
Heart Disease (i.e. heart attacks, bypass surgeries, arrhythmia)				
Kidney Disease				
Stroke				
Thrombophilia (i.e. Factor V Leiden)				
Thalassemia, Sickle Cell, or Hemophilia				
Autism spectrum or other developmental delay				
Other genetic disease, chromosomal disorder, or birth defect				
Cancer				

Please list any surgeries you've had & approximate year of procedure:

Have you had any hospital admissions other than for surgeries listed above, or childbirth? **Yes / No**

II. GYN & REPRODUCTIVE HEALTH

☐ Check here if menopausal and indicate age at menopause: _____

Age at Menarche (first period): _____

1st day of last menstrual period (if known): _____ Are you certain of this date? **Yes / No**

Length of Menstrual Cycles: Every _____ Days
(measured from 1st day of one period to 1st day of next period; i.e. every 28 days, or 21-38 days if irregular)

Have you received the HPV vaccine (Gardasil, Cervarix)? **Yes / No**

Are you currently sexually active? **Yes / No**

Do you have sex with men (M), women (W), or both (B)? **M / W / B**

Have you had any new sexual partners since your last GYN exam? **Yes / No**

Are you interested in being screened for sexually transmitted infections (STIs)? **Yes / No**

Do you use condoms for STI protection? ____ Always ____ Sometimes ____ Never

Do you use contraception / birth control, or take measures to avoid pregnancy? (____ N/A if menopausal)

- ☐ No, I am trying to conceive.
- ☐ No, or only sometimes, but I am open to pregnancy if it occurred.
- ☐ No, and I would like to obtain birth control.
- ☐ Yes. (Please mark contraceptive method below)

____ Nexplanon ____ Birth control Pills ____ NuvaRing or Patch ____ Condoms ____ Diaphragm
____ Partner had vasectomy ____ Tubal ligation ____ IUD ____ Withdrawal / partner pulls out
____ Fertility awareness / Natural family planning / 'Calendar method'

If using contraception, are you satisfied with your method of birth control? **Yes / No / n/a**

If No, why not?
_____

Please indicate if you have any of the following GYN concerns:

____ Heavy menses ____ Pelvic Pain ____ Irregular bleeding or periods
____ Painful periods ____ Painful intercourse ____ Urinary incontinence or leaking
____ PMS / PMDD ____ Low libido ____ Unusual vaginal discharge
____ Breast lump or changes ____ Recurrent (>2 per year) Yeast, BV, or UTI
____ Peri-menopause / Menopausal Symptoms (hot flashes, night sweats, vaginal dryness)

Have you ever had, or been diagnosed with, any of the following:

____ PCOS ____ Endometriosis ____ Fertility treatment ____ Ovarian cyst

Have you had any miscarriages? **Yes / No**
_____

Have you ever terminated a pregnancy (had an abortion)? **Yes / No**
_____

Have you ever had an ectopic pregnancy or a molar pregnancy? **Yes / No**

_____

Have you ever given birth? **Yes / No** (If Yes, please complete Obstetric History on Page 5)

III. SOCIAL HISTORY & LIFESTYLE

What is your relationship status (single, married, divorced, partnered, etc.)?

_____

Occupation (job, student, stay-at-home mom, etc.)?

_____ Living Situation: who shares your home

(roommates, husband & kids, dogs/cats, etc.)?

_____

What was the highest grade or degree you completed in school?

_____

Please note any dietary restrictions (i.e. vegetarian, vegan, gluten-free, Kosher, etc.)

_____

Do you exercise? ____ Never ____ Rarely (< once per week)
____ Sometimes (1-2x per week) ____ Regularly (nearly every day)

What do you do for exercise? _____

Do you currently, or have you ever, smoked cigarettes regularly? **Yes / No**

- If Yes, what age did you begin smoking? _____
- How much do you currently smoke? _____
- If you quit smoking, when did you quit? _____

Do you currently use marijuana? **Yes / No** _____

Do you regularly use other drugs? **Yes / No** Drug types:

_____

How often do you drink alcohol? ____ Never ____ Rarely (< once per week)
____ Sometimes (1-2x per week) ____ Regularly (nearly every day)

On a day when you drink, how many alcoholic beverages will you consume? _____

Have you ever gotten help for a substance use disorder? (i.e. AA/NA program, opioid treatment, etc.)? **Yes / No**

Have you ever experienced domestic violence, sexual assault, or abuse? **Yes / No**

Do you currently feel safe in your home? **Yes / No**

If you have children, do you have full custody of your children? **Yes / No**

Do you belong to a religious community, tribe, or otherwise hold cultural / spiritual beliefs which might affect your care?
Please note Y / N and specify your community: **Yes / No**

_____

IV. WELCOME!

✦ How did you hear about Southwest Midwives? (If you heard of us through a friend or relative, feel free to write their name!)

_____

✦ Is there anything else you'd like us to know, or address with you at your appointment?

_____

_____

V. OBSTETRIC HISTORY

Please complete chart below for any births you've had:

Birth Date M/D/Y	Child's Name	Sex M / F	Gest Age/ # Weeks Pregnant	Labor Length (hours)	Delivery Type: Vag or C/S	Baby's Weight	Location of Birth: If not at Mercy - Durango, note City, State; Home if home birth

Are all of your children currently living? **Yes / No**

_____

Do all of your children have the same father? **Yes / No**

_____

If you had a C-section: Do you know the indication (why it was done)? Please note in the space below.

_____

Please note any complications you had with previous deliveries (i.e. postpartum hemorrhage, shoulder dystocia, 4th degree tear, use of forceps or vacuum, placental abruption, etc.).

_____

_____