Medical History Questionnaire

Name________________________________DOB_______________Age_________Today's Date_______________

Reason for visit:

____

____

Obstetric History

Number of pregnancies:_________ Number of live birth: _____________
Number of vaginal deliveries: _____________ C-section: _________
Number of miscarriages or abortions:_________________
Any pregnancy complications?____

Gynecologic History

Age at first period______ First day of last period______ Are you past menopause/______ Since when? ______
Are you having any problems with your periods? ______ Since when? ______
Are your periods regular?______
If irregular: shortest interval______ longest interval______ average interval______
Usual number of days of bleeding each cycle: ______
Any spotting or bleeding between periods or during or after intercourse?______
Any pain with your periods? ______ What do you take for the pain? ______
Have you ever been sexually active? ______ Are you currently sexually active? ______
Do you currently use some form of family planning/contraception? ______ What type? ______
Date of last pap smear: ______ Any abnormal pap smears? ___________________________________
Any treatment on your cervix (LEEP / Laser / Cryotherapy) _______________________________________
Any history of any sexual transmitted diseases? ____
Gonorrhea? ______ Chlamydia? ______ PID? ______ Herpes? ______ HIV? ______
Date of last mammogram? _________________ Any abnormal mammograms? ___________________________
Any breast biopsies? ____

Medical/Surgical History **Do you or did you ever have:**

Arthritis	Yes / No	Depression / anxiety disorder	Yes / No
Blood Disorder	Yes / No	Migraine Headaches	Yes / No
Asthma	Yes / No	Stroke	Yes / No
Tuberculosis	Yes / No	Seizure disorder	Yes / No
Emphysema	Yes / No	Other neurologic disorders	Yes / No
Heart Disease	Yes / No	High.cholesterol	Yes / No
Heart Attack	Yes / No	Ulcers	Yes / No
High Blood Pressure	Yes / No	Irritable bowel syndrome	Yes / No
Thyroid Disease	Yes / No	Crohn's Disease/Ulcerative Colitis	Yes / No
Liver Disease	Yes / No	Breast Cancer	Yes / No
Kidney Disease	Yes / No	Other Cancer	Yes / No
Diabetes	Yes / No	Do you require antibiotics with dental procedures?	Yes / No
Blood clots in your legs/lungs	Yes / No		

Any other medical problems? ____

Please list any surgeries that you have had (include approx. year): _____________________________________

____

Medications

List all medications you are currently taking including prescriptions, over the counter, and vitamins/herbal supplements:

____

____

Allergies to Medications

Please list medication and reaction to the medication:____

____

Personal History

Are you: _____Married _____ Single _____ Separated _____ Divorced _____ Widowed

What is your occupation? ____

Do you smoke? Yes / No If yes, how much ______________ If quit, for how long________

Do you drink alcohol? Yes / No If yes, how often_______________ If quit, for how long________

Do you use any street drugs? Yes / No If yes, what kind ______________________________

Do you get regular exercise? Yes / No If yes, how often_______________ What kind ______________

Do you drink caffeine products? Yes / No If yes, how often_______________ How much ______________

Do you feel afraid of anyone in your household? ______________________

Has anyone at home hit your or tried to injure you?______________________

Family History Has anyone in your family had:

	Yes	No	Who?
Breast cancer			
Colon cancer			
Uterine cancer			
Ovarian cancer			
Other cancer			
Diabetes			
Hiqh blood pressure			
Heart disease or Heart attack			
Osteoporosis			
Any other family medical problems			