Patient Medical History

Date: ___________________________

Name: ____ Date of Birth: _____________________________ Age: _________________

The main reason for today's visit is ____

THE FOLLOWING MEDICAL QUESTIONAIRE IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE UNLESS YOU AUTHORIZE US TO DO SO

MENSTRUAL HISTORY

Last Menstrual Period: __________________ Previous Menstrual Period: _________________ Are your periods regular? ☐ Yes ☐ No

Age started menstruation:__________ How often do you menstruate? Every _______ days_____How long do your periods last? _______ days

Number of tampons soaked in 24 hours on the heaviest day of bleeding _______ Cramps are ☐ Mild ☐ Severe ☐ No cramps

Do you have spotting between periods? ☐ Yes ☐ No Do you have bleeding or spotting during intercourse? ☐ Yes ☐ No

Do you douche? ☐ Yes ☐ No How often? ________________ What douche preparation do you use? ___________________

MEDICATIONS PRESENTLY TAKING

Name of Drug (If known)	How often?	Name of Drug (If known)	How Often?
Calcium			
Vitamins			
Aspirin			
Antiflamatory Meds			

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list ____

CONTRACEPTIVE HISTORY

Are you using a Family Planning or birth control method now? ☐ Yes ☐ No Current type: ____

Are you satisfied with this method? ☐ Yes ☐ No If no, why

OBSTETRICAL HISTORY

Total Number of Pregnancies: _________ Number of Full Term Babies Born: ____________ Number of Premature Babies Born:_____________

Number of Miscarriages or Abortions: ___________ Number of Living Children: ___________

List any previous complications DURING PREGNANCY: ____

Have you ever been treated for infertility? ☐ Yes ☐ No If yes, how? ____

SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Yes	No		
D & C	☐	☐	Date ____________	Place _______________
Colposcopy	☐	☐	Date ____________	Place _______________
Conization	☐	☐	Date ____________	Place _______________
Cryosurgery	☐	☐	Date ____________	Place _______________
Cesarean Section	☐	☐	Date ____________	Place _______________
Hyterectomy	☐	☐	Date ____________	Place _______________
Removal of Ovaries	☐	☐	Date ____________	Place _______________
Removal of Tubes	☐	☐	Date ____________	Place _______________
Tubal Ligation	☐	☐	Date ____________	Place _______________

	Yes	No		
Masectomy	☐	☐	Date ____________	Place ____________
Repair of Bladder	☐	☐	Date ____________	Place ____________
Appendectomy	☐	☐	Date ____________	Place ____________
Laparoscopy	☐	☐	Date ____________	Place ____________
Blood Transfusion	☐	☐	Date ____________	Place ____________

Any other operations:

_______________________ Date _______________ Place ____________

_______________________ Date _______________ Place ____________

_______________________ Date _______________ Place ____________

Have you ever had to be put in the hospital for reasons other than childbirth or surgery? ☐ Yes ☐ No Date __________________________________

Place ____ Why?____

PAST MEDICAL HISTORY

HAVE YOU EVER HAD:

	Yes	No	Date/Age of Onset		Yes	No	Date/Age of Onset
1. High Blood Pressure	☐	☐	___________	16. Infection of Tubes or Ovaries	☐	☐	_____________
2. Diabetes	☐	☐	___________	17. Vaginal Infections	☐	☐	_____________
3. Cancer	☐	☐	___________	18. Endometriosis	☐	☐	_____________
4. Heart Trouble or Rheumatic Fever	☐	☐	___________	19. Epilepsy	☐	☐	_____________
5. Hepatitis or Jaundice	☐	☐	___________	20. Thyroid Problems	☐	☐	_____________
6. Kidney Disease or Bright's Disease	☐	☐	___________	21. Stroke	☐	☐	_____________
7. Bladder Infections	☐	☐	___________	22. Do you have any bleeding tendency?	☐	☐	_____________
8. Asthma or Hay Fever	☐	☐	___________	23. Ulcers	☐	☐	_____________
9. Migraine Headaches	☐	☐	___________	24. Gall Bladder Trouble	☐	☐	_____________
10. Pneumonia	☐	☐	___________	25. Thrombophlebitis (Blood Clots in the Veins)	☐	☐	_____________
11. Arthritis or Rheumatism	☐	☐	___________	26. Sickle Cell	☐	☐	_____________
12. Nervous Breakdown (or any emotional problem)	☐	☐	___________	27. Any other serious illness?	☐	☐	_____________
13. German Measles	☐	☐	___________	28. Infection of Tubes or Ovaries	☐	☐	_____________
14. Anemia	☐	☐	___________	29. Infection of Tubes or Ovaries	☐	☐	_____________
15. Venereal Disease (Syphilis, Gonorrhea, Herpes, Condyloma or Venereal Warts)	☐	☐	___________	30. Have you ever had a "bad" Pap Smear?	☐	☐	_____________

FAMILY HISTORY

Relationship	Age	Health Now	Age at Death	Cause of Death		Relationship	Age	Health Now	Age at Death	Cause of Death
Father						No. of Brothers _____				
Mother						No. of Sisters _____				

Has any blood relative (Parents, Grandparents, Brothers, Sisters, Children) ever had:

Breast Cancer ☐ Yes ☐ No Who ____________________ Heart Trouble ☐ Yes ☐ No Who _______________________

Cancer ☐ Yes ☐ No Who ____________________ High Blood Pressure ☐ Yes ☐ No Who _______________________

Diabetes ☐ Yes ☐ No Who ____________________ Congenital Defects ☐ Yes ☐ No Who _______________________

HABITS

1. Sleeping Well? ☐ Yes ☐ No Average number of hours _______ 2. Do you smoke tobacco? ☐ Yes ☐ No How much _________________

3. Alcoholic beverages? ☐ Yes ☐ No How much_____________ 4. Did you ever smoke? ☐ Yes ☐ No When did you quit? ___________

5. Weight: Now _______ pounds One year ago _______ pounds Most you ever weighed? ______ pounds When? ________________________

6. Last Medical Exam: Date ______________ Reason____________________________________ Date of Last Pap _____________________________

7. Do you exercise regularly? ☐ Yes ☐ No

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Married (How long): ________ Husband's Name: ______________________________ Age of Partner: ______ Health of Partner: ____________

Your Signature:____ Date: ____