Medical History Questionnaire

Date of Visit: _____ /_____ /_____ Patient Name: ________________________________ Date of Birth: _____ /_____ /______

Primary Care Physician: ________________________________ Patient Type: ☐ New Patient ☐ Current Patient (seen in past 3 years)

Reason for Visit: ☐ Annual/Preventative Exam ☐ OB Exam ☐ GYN Exam Problem: ______________________

☐ Other: ____

Pregnancy History

Number of: Pregnancies ____________ Full Term Deliveries __________ Premature Deliveries __________

Miscarriages __________ Ectopics: __________ Abortions _________ Living Children __________

1. Delivery Date (year): ________ Gender (circle): M / F Birth Weight: ________ Weeks at delivery: ____________

   Delivery Type (circle): Vaginal / C-section Complications: ______________________________

2. Delivery Date (year): ________ Gender (circle): M / F Birth Weight: ________ Weeks at delivery: ____________

   Delivery Type (circle): Vaginal / C-section Complications: ______________________________

3. Delivery Date (year): ________ Gender (circle): M / F Birth Weight: ________ Weeks at delivery: ____________

   Delivery Type (circle): Vaginal / C-section Complications: ______________________________

Additional Pregnancies: ____

Menstrual History

Age of first menstrual period: ________ Regular monthly cycles? (circle): Yes / No / N/A

First day of last period : ______ /______ /______ Current Method of contraception: ______________________

History of STDs: ____

Preventative Care

Last Pap Smear: ______ /______ /______ Previous Abnormal Pap? (circle): Yes / No Gardasil Vaccine? (circle): Yes / No

Last Mammogram: ______ /______ /____ Where: ________________ Previous Abnormal Mammo? (circle): Yes / No

Last Cholesterol Test: _____ /_____ /_____ Last Colonoscopy: ____ /____ /____ Last DEXA (Bone Density): ____ /_____ /_____

Current Medications (Including Over-the-Counter and Vitamins)

Name: ______________________ Dosage: ____________________ Frequency: __________________

Name: ______________________ Dosage: ____________________ Frequency: __________________

Name: ______________________ Dosage: ____________________ Frequency: __________________

Name: ______________________ Dosage: ____________________ Frequency: __________________

Name: ______________________ Dosage: ____________________ Frequency: __________________

Allergies (Drugs and/or Food)

Type: ________________________________ Reaction: ________________________________

Type: ________________________________ Reaction: ________________________________

Type: ________________________________ Reaction: ________________________________

Surgeries and/or Major Injuries

Type: ______________________________________ Year: ____________

Type: ______________________________________ Year: ____________

Type: ______________________________________ Year: ____________

Social History

Regular Exercise? (circle): Yes / No Times per week: ________

Caffeine Intake? (circle): Yes / No Servings per day: ____ Alcohol use? (circle): Yes / No Drinks per week: ____

Tobacco Use? (circle): Yes / No If yes, describe: ____________ Recreational drug use? (circle): Yes / No

Medical History
Check box if you have a history of:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Neurologic Disorder
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ Polycystic Ovarian Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Uterine Fibroids

Family History
Check box and list relation (e.g. mother, father, brother, sister, etc.):

- ☐ Alcoholism __________
- ☐ Autoimmune Disorder __________
- ☐ Birth Defects __________
- ☐ Blood Clots __________
- ☐ Breast Cancer __________
- ☐ Cerebral Palsy __________
- ☐ Cervical Cancer __________
- ☐ Colon Cancer __________
- ☐ Cystic Fibrosis __________
- ☐ Diabetes __________
- ☐ Endometrial Cancer __________
- ☐ Epilepsy __________
- ☐ Denetic Disorder __________
- ☐ Heart Disorder __________
- ☐ High Blood Pressure __________
- ☐ High Cholesterol __________
- ☐ Kidney Abnormalities __________
- ☐ Liver Disease __________
- ☐ Mental Health Disorder __________
- ☐ Osteoporosis __________
- ☐ Ovarian Cancer __________
- ☐ Pancreatic Cancer __________
- ☐ Sickle Cell Disease __________
- ☐ Stroke __________
- ☐ Thyroid Disease __________
- ☐ Uterine Cancer __________
- ☐ Other __________

Symptoms
Check box if you have any of these symptoms:

<u>Reproductive & Urinary Symptoms</u>

- ☐ Abnormal Bleeding
- ☐ Bleeding After Sex
- ☐ Bleeding Between Periods
- ☐ Bleeding Post-Menopause
- ☐ Blood in Urine
- ☐ Burning Urination
- ☐ Hot Flashes
- ☐ Menstrual Cramps
- ☐ Night Sweats
- ☐ Painful Intercourse
- ☐ Pelvic Pain
- ☐ Sexual Difficulties
- ☐ Urinary Incontinence
- ☐ Urination Frequency/Urgency
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness

<u>General Symptoms</u>

- ☐ Blood in Stool
- ☐ Breast Mass/Discharge
- ☐ Chest Pain/Palpitations
- ☐ Constipation
- ☐ Cough
- ☐ Depression/Anxiety
- ☐ Diarrhea
- ☐ Dizziness/Fainting
- ☐ Easy Bruising
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Jaundice/Liver Disease
- ☐ Muscle/Joint Pain
- ☐ Nasal Drainage
- ☐ Nausea/Vomiting
- ☐ Numbness/Tingling
- ☐ Shortness of Breath
- ☐ Swollen Legs
- ☐ Varicose Veins/Clots
- ☐ Weight Changes
- ☐ Wheezing
- ☐ Other Symptoms __________

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