Patient Medical History

A close up of a logo

Description automatically generated

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 |  |  |  | Yes | No |  |  |
| D & C | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | Masectomy | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_ |
| Colposcopy | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | Repair of Bladder | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_ |
| Conization | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | Appendectomy | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_ |
| Cryosurgery | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | Laparoscopy | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_ |
| Cesarean Section | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | Blood Transfusion | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_ |
| Hysterectomy | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | Any other operations: |  |  |  |  |
| Removal of Ovaries | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Place \_\_\_\_\_\_\_\_\_ |
| Removal of Tubes | □ | □ | Date \_\_\_\_\_\_\_\_ | Place \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Place \_\_\_\_\_\_\_\_\_ |
| Tubal Ligation | □ | □ | 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 Issues/Removal | □ | □ | \_\_\_\_\_\_\_\_\_\_ |
| 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 an "abnormal" 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 |  |  |  |  |  | # of brothers you  have? \_\_\_\_\_\_ |  |  |  |  |
| Mother |  |  |  |  |  | # of sisters you  have? \_\_\_\_\_\_ |  |  |  |  |

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 or Partner: \_\_\_\_\_\_\_\_\_\_ Health of Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_