MEDICAL HISTORY QUESTIONAIRE

Date_____

Name_____ Age_____

The purpose of having you fill out this questionnaire is for you to furnish us with important medical information. It provides us with a background of your medical history and any health problems you may have had in the past. This will allow us to give you more thorough care. All of the information you give us is confidential and will not be released unless you give us permission to do so.

What is the reason for your visit today? _____

SURGICAL HISTORY:
Please list any surgeries that you have had. Include abortions, ectopic pregnancy, D&C, treatments for abnormal PAPs or any other surgeries:

_____

_____

PREGNANCY/OB HISTORY:
How many times (total) have you been pregnant? _____

Number of:
Vaginal/natural deliveries _____ Cesarean sections _____ Miscarriages _____
Abortions _____
Ectopic (tubal) pregnancy _____

Did you experience any pregnancy complications? If so, please list the complication(s).

_____

GYNECOLOGIC HISTORY
Has your PAP result ever come back with pre-cancerous cells/cervical dysplasia/HPV? _____

How old were you when the PAP smear was abnormal? _____

What treatment did you receive for the abnormal PAP? _____

Have you ever been diagnosed or treated for any sexually transmitted diseases? (please check all that apply)

- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Syphilis
- ☐ Genital Warts
- ☐ Trichomonas
- ☐ HIV
- ☐ HPV
- ☐ Hepatitis
- ☐ Other

ALLERGIES:
Are you allergic to Latex? _____

List any medications you are allergic to: _____

Other allergies? (ex. Shellfish, Iodine, etc) _____

MEDICATIONS:
Please list all medications or treatments you are currently taking: (Include any over-the counter or herbal medicines)

_____

_____

_____

MEDICAL HISTORY
List any / all medical problems (***not surgeries***) that you have seen a doctor for, take medicine for, or have ever been in the hospital for?

_____

_____

_____

FAMILY MEDICAL HISTORY

Do your **parents**, **brothers**, **sisters** or **children** have a history of any of the following (please circle):

Diabetes	Stroke	High blood pressure	Heart attacks
Ovarian Cancer	Uterine Cancer	Breast Cancer	Colon Cancer
Blood clotting disorder	Bleeding disorders	Liver disease	Osteoporosis

Any other significant medical problems (not listed above) that have affected your family?

_____

WHAT METHOD DO YOU USE TO PREVENT PREGNANCY? i.e. birth control (if applicable)?

_____

WHEN WAS THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD? (the day your period STARTED, if applicable – month/day)

_____

WHEN WAS YOUR LAST PAP PERFORMED? (year) _____

WHEN WAS YOUR LAST MAMMOGRAM PERFORMED? (if applicable, year) _____

WHEN WAS YOUR LAST COLONOSCOPY PERFORMED? (if applicable, year) _____

SOCIAL HISTORY
Do you smoke? _____

How often do you drink alcoholic beverages?
_____ never _____ rarely _____ socially _____ most every day

Do you use any recreational/street drugs or any mood altering medications not prescribed to you? _____

Marital status: _____ married _____ single/never married _____ single/divorced _____ single/widowed

How many sexual partners have you had in the past year? _____