MEDICAL HISTORY QUESTIONAIRE

PLEASE ANSWER ALL THAT IS APPLICABLE

Date_________________

Name__________________________________ Age/ DOB _________ Gender M / F

Primary Care Physician:____

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? **Y / N**
How old were you when the PAP smear was abnormal? _________
What treatment did you receive for the abnormal PAP? ________________
Do you have problems with bladder control, leaking urine, frequent urination, etc. **Y / N**

Have you ever been diagnosed / treated for any sexually transmitted diseases? (please circle 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? __________

All of the information you give us is confidential and will not be released unless you give us permission to do so.