Patient Medical Questionnaire

NAME: _____

DATE: _____

PCP: _____

Marital status: S M W D Partner: Male or Female

When was your last physical exam? _____

First day of your last period? _____

Date of your last Pap smear? _____

Age for first menstrual cycle? _____

Are your menstrual cycles: irregular or regular (circle one)

How often is your menstrual cycle? _____

How many days does your period last? _____

How many pads/tampons do you use on the heaviest day of your period? _____

Any significant clotting? (Please circle) YES NO

Severe cramping? YES NO

Do you use medicine for pain during your period? YES NO

Do you stay in bed, miss work or school? YES NO

Any bleeding or spotting between periods? YES NO

Any bleeding or spotting after sex? YES NO

What form of pregnancy prevention do you use?_____

PAIN

Do you have any lower pelvic or abdominal pain between periods? YES NO

Medicine used: _____

Do you have pain during or after sex? YES NO

DISCHARGE

Do you have any problems with vaginal discharge? YES NO

Have you been treated for vaginal Infections in the past? YES NO

How many times? _____

What kind of infections were they?

[ ] Trichomonas [ ] Yeast [ ] Bacterial Vaginosis

[ ] Other: _____

PAST GYNECOLOGICAL HISTORY

Have you ever had: Venereal disease, Gonorrhea, Syphilis, Chlamydia, vaginal or rectal warts? YES NO

Herpes? YES NO

Pelvic or tube infection? YES NO

Abnormal Pap smears? YES NO

Have you received the Gardasil vaccine? YES NO

If yes, all 3 injections? YES NO

Have you had a colposcopy or Leep for treatment of an abnormal Pap smear? YES NO

If yes, when? _____

Have you had difficulty becoming pregnant? YES NO

Any treatment for infertility? YES NO

OBSTETRICAL HISTORY

Number of full term deliveries: _____Vaginal _____C-section

Number of preterm deliveries: _____Vaginal_____C-section

Number of miscarriages: _____ Abortions: _____

Did you breastfeed? YES NO

GENITOURINARY

Do you have or have you had recently:

Burning upon urination? YES NO

Blood in urine? YES NO

Do you wet yourself involuntarily? YES NO

When does this happen? _____

Have you had bladder or kidney infections? YES NO

How many times? _____

When was the last time you had one? _____

Do you wake up often at night to urinate? YES NO

GASTROINTESTINAL

Are you often constipated? YES NO

Any change in bowel habits? YES NO

Do you have frequent diarrhea? YES NO

Any known ulcer? YES NO

Any known liver, bowel or stomach disease? YES NO

OTHER

Breast lumps or surgery? YES NO

Breast discharge? YES NO

Mammogram NO YES

Last one: _____

SEXUAL HISTORY

Age of first intercourse? _____

Are there any problems with sexuality that you would like to discuss? YES NO

Are you having marital or relationship problems? YES NO

Have you had more than 5 lifetime sexual partners? YES NO

Do you have any questions about AIDS or other sexually transmitted diseases that you would like to discuss? YES NO

Do you feel safe at home? YES NO

HEALTH HABITS

Do you currently smoke? YES NO

If yes, how much, how often? _____

If no, have you ever smoked? YES NO

If yes, when did you quit? _____

Do you drink alcohol? YES NO

How often and how much? _____

Did you ever think that you might have a problem with alcohol? YES NO

CONTINUE ON OTHER SIDE

Patient Medical Questionnaire

Does anyone close to you have a drinking problem? YES NO
Do you wear seat belts? YES NO
Do you perform breast self-exams? YES NO
How often? _____
Do you exercise regularly? YES NO
What type?_____
Are you dieting? YES NO
Are you a vegetarian? YES NO
Do you work outside the home? YES NO
What type of work?_____
Do you have difficulty sleeping? YES NO
Have you had any recent immunizations? YES NO
Do you use any street drugs? YES NO

ALLERGIES

Do you have a latex allergy? YES NO
Are you allergic to any foods or supplements? YES NO
Are you allergic to any drugs? YES NO
If yes please list:

DRUG	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

Do you have asthma or hay fever? YES NO
If yes, what type of treatment?
_____
Have you ever had Rheumatic fever, heart murmur or other heart disease? YES NO
High blood pressure YES NO
Diabetes YES NO
Tuberculosis YES NO
Anemia YES NO
Hepatitis YES NO
Phlebitis or Deep Vein Thrombosis (DVT) YES NO
Pulmonary embolism YES NO
Anxiety YES NO
Severe depression YES NO
Psychiatric illness YES NO
Thyroid disorder YES NO
Are you under a doctor's care now? YES NO
If yes, what are you being treated for?
_____
_____

Please list any surgery you have had and what year the surgery was performed:
_____
_____
_____
_____

FAMILY HISTORY

List blood relatives, living and deceased, who have had any of the following conditions and write their relationship to you (for example maternal Aunt):
Breast Cancer_____
Ovarian Cancer_____
Uterine Cancer_____
Colon Cancer_____
Birth Defects_____
High Blood Pressure_____
High Cholesterol_____
Heart Attack_____
Diabetes_____
Does any member of your family have anemia or genetic disorders? YES NO
Are there any medical problems not mentioned that run in your family? YES NO
If yes, what are they?_____
_____

	Age	State of health	Ailments
Mother			
Father			
Brother			
Sister			

CURRENT MEDICATIONS/SUPPLEMENTS

Drug	Date started	Dosage	How often	Prescribing Physician