



MEDICAL HISTORY QUESTIONNAIRE

Name _____

Date ____ / ____ / ____

GYNECOLOGICAL HISTORY:

Describe your problem

When was your last Paps test: _____ Was it normal _____

When was the first day of your menstrual period _____ Was it normal _____

How many days are between the onset of one menstrual period and the onset of the next one _____

How long do you flow with your menses _____ days. Are they (light), (medium), (heavy), or (clots)

Do you have bleeding or spotting between menstrual periods _____

Describe

Do you have pain with your menstrual periods _____ Describe _____

Do you have hot flushes _____ Describe _____

At what age did you have your first menstrual period _____

At what age did your breast start developing _____

Did you have pain with your periods as an adolescent _____ Describe _____

Do you have intercourse _____ Do you have bleeding with intercourse _____

Do you have pain with intercourse _____ How often do you have intercourse _____ per week

Do you have any other problem(s) with intercourse _____ Describe _____

Have you ever had a pelvic infection _____, Pelvic surgery _____

What type birth control do you use Birth control pills Name _____

IUD Name _____

Rhythm Foam

Condoms Depo-Provera

Diaphragm Norplant

Tubal Ligation Vasectomy

OPERATIONS

<i>Date</i>	<i>Procedure</i>	<i>Hospital</i>	<i>Surgeon</i>	<i>Problem</i>

DISEASES

List diseases you have had in the past

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS

List medications you are presently taking

<i>Medication</i>	<i>Dosage</i>	<i>For How Long</i>	<i>Problem</i>

ALLERGIES

<i>Medication / Agent</i>	<i>Type of Reaction</i>		<i>Medication / Agent</i>	<i>Type of Reaction</i>

OTHER HOSPITAL ADMISSIONS

<i>Date</i>	<i>Hospital</i>	<i>Problem</i>	<i>Doctor</i>

REVIEW OF SYSTEMS

CARDIOVASCULAR

Do you have or have you had:

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <u>None of these</u> | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Fluttering of heart |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Leg cramps after walking | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cardiovascular surgery |
| <input type="checkbox"/> Electrocardiogram | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Treadmill |
| <input type="checkbox"/> Heart Catherization | <input type="checkbox"/> Echocardiogram | |
| | <input type="checkbox"/> Other | |

Please explain below:

PULMONARY

Do you have or have you had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> <u>None of these</u> | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood clot to lung | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chest Surgery |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Collapsed lung | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Chronic/productive cough | |
- How much _____ pkg./day For how long _____ years

Please explain:

GASTROINTESTINAL

Do you or have you had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> <u>None of these</u> | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Diverticuli | <input type="checkbox"/> Vomiting blood |
| <input type="checkbox"/> Chronic or severe diarrhea | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Chronic heartburn |
| <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Stool incontinence | <input type="checkbox"/> Food intolerance |
| <input type="checkbox"/> Stomach or bowel x-rays | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sigmoidoscopy |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Liver Biopsy |
| <input type="checkbox"/> Family history of bowel cancer | <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Positive HIV |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis vaccination | |
| <input type="checkbox"/> Alcohol _____ Beers / d. _____ Wine / d. _____ Drinks / d. | | |
| <input type="checkbox"/> Drug Habit / usage _____ | | |

Please explain:

GENITOURINARY

Do you have or have you had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <u>None of these</u> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Dialysis | <input type="checkbox"/> IVP |
| <input type="checkbox"/> GU surgery | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Leaking of urine | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Feeling of urgency to urinate | <input type="checkbox"/> Blood in urine | |
| | <input type="checkbox"/> GU Medications | |

Please explain:

ENDOCRINE

Do you have or have you had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Endocrine dysfunction | <input type="checkbox"/> <u>None of these</u> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Thyroid dysfunction | <input type="checkbox"/> Excess hair growth |
| <input type="checkbox"/> Family history of excess hair | <input type="checkbox"/> Extreme thirst | |
| | <input type="checkbox"/> Other | |

Please explain:

REVIEW OF SYSTEMS (cont.)

NEUROLOGIC

Do you have or have you had:

- Headaches
- Loss of balance
- Loss of hearing
- Seizure disorder

- None of these**
- Areas of numbness
- Loss of smell
- Loss of vision
- Epilepsy

- Depression
- Loss of taste
- Muscle weakness
- Psychiatric Disorder

Please explain:

MUSCULOSKELETAL

Do you have or have you had:

- Arthritis
- Tendon injuries
- Other

- None of these**
- Bone fractures
- Deformities

- Muscle loss
- Amputation

Please explain:

FAMILY HISTORY

	Age	Living	If Dead Age & Cause of Death	Health
<i>Father</i>				
<i>Mother</i>				
<i>Sister</i>				
<i>Brother</i>				
<i>Son</i>				
<i>Daughter</i>				

Is there a family history of:

Relationship

Diabetes _____

High blood pressure _____

Heart disease _____

Kidney disease _____

Thyroid disease _____

Cancer *Type:* _____

Premature Menopause _____ *Age* _____

Genetic of Hereditary _____

Please explain any of above:
