Medical History Questionnaire

Patient Name: ________________________________ Date of Birth: ____________

Date:

In order to help us provide you with the best medical care, please complete this form and the medication list in as much detail as possible. Please bring the completed form with you at the time of your first visit.

Please write, in your own words, the nature of your current gynecologic, colorectal or urologic medical problem.

Problem(s): **For how long:**

Prior Treatment(s):

PLEASE FILL IN THE FOLLOWING INFORMATION:

PAST OBSTETRICAL HISTORY	Physician Notes
Number of pregnancies	
Number of live births	
Number of miscarriages	
Number of abortions	
Type of deliveries: Vaginal ___________ C/Section ___________ Forceps ___________	

GYNECOLOGIC HISTORY	Physician Notes
Age when period first started:	
First day of your last period:	
How long does your period last?	
Are your periods regular? YES NO	
# of days from the start of 1 period to the start of the next period:	
Method of birth control:	
DES exposure (diethylstilbestrol- a synthetic form of estrogen):	
Have you gone through menopause? YES NO If yes, at what age?	

Do you have a Gynecologist? If yes, who?				
	Bleeding between periods	If yes, duration:		
	Bleeding after intercourse	If yes, duration:		
	Heavy menstrual periods	If yes, duration:		
	Pain with periods	If yes, duration:		
Date of Last Pap Smear				
	Normal	Yes	No:	
Date of Last Mammogram				
	Normal	Yes	No:	

Have you had any treatment to your cervix?		Yes No	
	Cautery	When?	
	Cryosurgery	When?	
	other	When?	

Have you had any of the following? Please check if you ever had:			
	Infection of your female organs**?**	When?	
	Venereal disease?	When?	
	Herpes?	When?	
	Venereal warts or Condylomata?	When?	

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PAST MEDICAL HISTORY					
As an adult have you had?					
	Heart Disease		Liver Disease		Tuberculosis
	Heart Murmur		Pneumonia		Serious injuries / accidents
	Kidney Infection		Thyroid Disease		High Blood Pressure
	Bladder Infection		Asthma		Diabetes
	Cancer, type:		Antibiotics before procedures		Any implantable devises
	Other:				
Physician Notes:					

SURGICAL HISTORY		Physician Notes
Have you had any blood transfusions? YES NO If yes, any reactions?		
Have you had any operations? YES NO		
If yes, please list below:	When?	
	When?	
	When?	
	When?	
	When?	
	When?	

DETAILED HISTORY			
Do you have a problem with?			
Uncontrolled loss of urine with coughing, laughing, or physical activity?	YES	NO	
If yes, for how long?			
Do you have a strong urge to urinate?	YES	NO	
Do you sometimes not make it to the bathroom in time?	YES	NO	
Do you wear a pad?	YES	NO	
If yes, what kind? / How many pad / day?			
On average, how often do you urinate: / Daytime? / Nighttime?			
Do you experience a burning sensation when you urinate?	YES	NO	
Do you have difficulty urinating?	YES	NO	
Do you feel that your bladder does not empty completely?	YES	NO	
Do you have vaginal dryness?	YES	NO	
Do you get vaginal infections frequently?	YES	NO	
Are you sexually active at this time?	YES	NO	
How long have you been with your current sexual partner?	YES	NO	
Is your sex life satisfactory for you?	YES	NO	
Do you have any questions about sex that you would like to talk about?	YES	NO	
Have you been a victim of domestic violence or sexual abuse?	YES	NO	

Do you have any problems with:						
Diarrhea?	YES	NO	Anal / Rectal bleeding?	YES	NO	
Constipation?	YES	NO	Change in bowel habits?	YES	NO	
Fecal incontinence?	YES	NO	Anal Pain?	YES	NO	
Frequency of Bowel Movements?	_______ / day		______ / night			
Have you had a colonoscopy?	YES	NO	If yes, When:			

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Physician Notes:

FAMILY HISTORY		Physician Notes
Has anyone in your family had any of the following? If so, please list family relationship.		
	Relation	
High blood Pressure		
Diabetes		
Colitis		
Stroke		
Heart Disease		
Bleeding problems		
Breast Cancer		
Colon/Rectal Cancer		
Other Cancer		
Other:		

Father:	Alive	Deceased: Cause? Age?	**Mother:**	Alive	Deceased: Cause? Age?

SOCIAL HISTORY					Physician Notes
Current marital status?					
Married	Single	Divorced	Widowed	Separated	
Number of people living in your household?		Your Occupation?			
Physician Notes:					

HEALTH HABITS					Physician Notes
Do you smoke?	YES NO	If yes, For how long?		How many packs per day?	
Do you use:	Alcohol	Marijuana	Cocaine	Other:	
Do you eat regular meals?		YES NO	Breakfast?	YES NO	
Do you exercise regularly?		YES NO	If yes, how?		
What do you do to relax?					
Do you consider yourself healthy?					

MEDICATIONS		Physician Notes
Do you have any **allergies to medications**?	YES NO	
If yes, please list: MEDICATION	REACTION	

Please complete separate sheet as well. List all medicines which you are currently taking.
& include contraceptives, hormones, vitamins and over the counter medications.

Medication	Dosage	Physician Notes

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Review of Symptoms: **Please check if any of the following apply:**

	Constitutional Symptoms			**Allergic/Immunologic**	
	weight loss			Hay Fever	
	weight gain			food allergies	
	change in appetite			**Integumentary**	
	fever			skin rash	
	chills			boils	
	headache			persistent itch	
	Other			change in any mole	
	Eyes			Other	
	blurred vision			**Musculoskeletal**	
	double vision			joint pain	
	pain			neck pain	
	Other			back pain	
	Endocrine			difficult walking	
	excessive thirst			Other	
	too hot/cold			**Ear/Nose/Throat**	
	tired/sluggish			ear infection	
	Other			ear pain	
	Gastrointestinal			ringing in ears	
	abdominal pain			decreased hearing	
	nausea/vomiting			sore throat	
	indigestion/heartburn			sinus problem	
	swallowing problems			frequent bloody noses	
	ulcers			false teeth	
	gallbladder problems			Other	
	liver problems			**Genitourinary**	
	black stools			urinary retention	
	Other			kidney stones	
	Cardiovascular			urinary tract infection	
	chest pain			Other	
	varicose veins			**Hematologic/Lymphatic**	
	pain in leg with exercise			swollen glands	
	Other			blood clotting problem	
	Respiratory			anemia	
	wheezy/asthma			HIV test	
	cough			Other	
	coughing up blood			**Breast**	
	shortness of breath			breast pain	
	other			breast lump	

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	Psychiatric			nipple discharge	
	psychiatric treatment			mammogram	
	depression			if so, date__________	
	thoughts of suicide				
	Other:				