PATIENT HISTORY QUESTIONNAIRE

PATIENT NAME: .... **DOB** .... **DATE COMPLETED:** ....

PERSONAL MEDICAL HISTORY: Please Circle ***Yes*** or ***No*** if you have any of the following medical problems

Heart Disease	Yes	No	DVT (Blood Clots)	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Mitral Valve Prolapse	Yes	No	Asthma	Yes	No
Heart Murmurs	Yes	No	Urinary Tract Infection	Yes	No	Hepatitis	Yes	No
Kidney Disease	Yes	No	Endometriosis	Yes	No	Uterine Fibroids	Yes	No
Seizures	Yes	No	Arthritis	Yes	No	Thyroid Disease	Yes	No
Breast Problems	Yes	No	Cancer	Yes	No	Blood Transfusions	Yes	No
Depression/Anxiety	Yes	No	Tuberculosis	Yes	No	Jehovah Witness	Yes	No
Skin Disorder	Yes	No	Migraines	Yes	No	Anorexia/Bulimia	Yes	No
Intestinal Problems	Yes	No	Anemia/Blood Disease	Yes	No	Osteoporosis	Yes	No
Sexually Transmitted Disease	Yes	No	Vision or Hearing Impairment	Yes	No	High Cholesterol	Yes	No
History of Ectopic Pregnancy	Yes	No				Jaundice (Yellowing of the skin)	Yes	No

FAMILY HISTORY: Please place a ***check mark*** in the box of the blood related relatives that have the following:

CONDITION	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENTS	M.D. Use Only
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Kidney Disease						
Arthritis						
Endometriosis						
Osteoporosis						
DVT (Blood Clots)						
Cancer						

CURRENT MEDICATIONS: Please list all ***Medications and Dosage*** you are currently taking

....

....

ALLERGIES: Please list all ***Medications*** from which you have had an allergic reaction

....

....

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PAST HOSPITALIZATIONS/SURGERIES: ***Please list all previous hospitalizations and/or surgeries***

Year	Surgery

Year	Surgery

GYNECOLOGICAL HISTORY:

1. Menstrual History:
   - (a) How old were you when your periods first started? ....
   - (b) How many days apart are your period? ....
   - (c) How many days does your period last? ....
   - (d) Do you have cramping or pain? ....
   - (e) Is your flow light, medium or heavy? ....
   - (f) Are you currently having problems with your period? ....

2. Pap Smear History:
   - (a) When was your last pap smear? ....
   - (b) Was it normal? ....
   - (c) Have you ever had an abnormal pap? ....
   - (d) If yes, what was done? ....

3. Breast History:
   - (a) Have you ever had any breast problems? ....
   - (b) When was your last mammogram? ....
   - (c) Have you ever had an abnormal mammogram? ....

OBSTETRICAL HISTORY:

How many times have you been pregnant? .... How many children do you have? ....

MO/YR	GEST AGE	LABOR	DEL/TYPE	WT	SEX	NAME	REMARKS

SOCIAL HISTORY: *Please answer the following questions*

Marital Status: Single Married Widow Divorced Defacto

Partners Name: ____________________ Partners DOB: ____________________

Your Occupation: ____________________ Partners Occupation: ____________________

Do you smoke? Y or N How much per day? ____________________

How much alcohol do you consume per day? ____________________

Are you currently sexually active? ____________________

Are you currently using any type of birth control? ____________________

PATIENT STATEMENT: *To the best of my Knowledge, the above information is accurate and complete. I consent to minor procedures to be carried out in the rooms after recommendation by my Specialist and after consultation with myself.*

Signed: ____________________ Date: ____________________