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MEDICAL HISTORY QUESTIONAIRE

Name: _____DOB: _____ Date:_____

Languages Spoken: _____ _____ _____

Reason for Visit: _____

Allergies

Are you allergic or have you had a reaction to the following:

NO	YES	NO	YES
☐ Local Anesthesia	☐	☐ Codeine or Narcotics	☐
☐ Penicillin	☐	☐ Barbiturates, Sedatives	☐
☐ Sulfur or other antibiotics	☐	☐ Sleeping Pills	☐
☐ Aspirin	☐	☐ Latex allergy	☐
☐ Iodine	☐	☐ I/V Dyes	☐
☐ Food _____	☐	☐ Seasonal _____	☐
		☐ Other _____	☐

Social H/O

NO	YES	Now / Past	
☐ Alcohol	☐	☐	☐ How much?
☐ Smoking	☐	☐	☐ How much?
☐ Recreational Drugs	☐	☐	☐
☐ Cocaine	☐	☐	☐
☐ Heroin	☐	☐	☐
☐ PCP / LSD	☐	☐	☐
☐ Other	☐	☐	☐

Current Medications

Please list any medications you are presently taking

Prescription / Type _____

_____

_____

Non Prescription _____

_____

_____

Explain:

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

NO	YES	Relationship
☐ Endometrial (uterine) Ca	☐	_____
☐ Ovarian Ca	☐	_____
☐ Breast Ca	☐	_____
☐ Colon Ca	☐	_____
☐ Birth Defects	☐	_____
☐ Multiple Pregnancy	☐	_____
☐ Arthritis	☐	_____
☐ Diabetes	☐	_____
☐ Seizures / epilepsy	☐	_____

NO	YES	Relationship
☐ High blood pressure	☐	_____
☐ Stroke	☐	_____
☐ Glaucoma	☐	_____
☐ Heart Disease	☐	_____
☐ Kidney Disease	☐	_____
☐ Endometriosis	☐	_____
☐ Suicide Attempt	☐	_____
☐ Other :	☐	_____
_____		_____

Others _____

PREGNANCY HISTORY

NO		YES
☐	Have you ever been pregnant?	☐
☐	Have you had any complications with any pregnancy or child birth?	☐
	If yes, Explain: _____	
☐	Have you had any children with birth defects?	☐
	If yes, Explain: _____	
	How many births have you had? _____	

Live Births:

Dates _____ Normal Delivery ☐ Assisted ☐ C/Section ☐ Wt. _____ M ☐ F ☐ Full Term ☐ Pre-term ☐
Dates _____ Normal Delivery ☐ Assisted ☐ C/Section ☐ Wt. _____ M ☐ F ☐ Full Term ☐ Pre-term ☐
Dates _____ Normal Delivery ☐ Assisted ☐ C/Section ☐ Wt. _____ M ☐ F ☐ Full Term ☐ Pre-term ☐
Dates _____ Normal Delivery ☐ Assisted ☐ C/Section ☐ Wt. _____ M ☐ F ☐ Full Term ☐ Pre-term ☐

NO	**Did you ever have**:	YES	
☐	Stillbirths (fetal death)	☐	
☐	Elective Abortion	☐ (if yes, how many)	_____
☐	Miscarriage	☐	_____
☐	Ectopic Pregnancy	☐	_____
☐	Did you have any complications with any pregnancy?	☐	

If Yes, Explain:_____

Menstrual H/O

How old were you when your first period (menses) started? _____
Are your menstrual cycles Regular _____ Irregular _____
How many days between the first day of one period to the first day of the next period?

NO That is, periods come every _____ days. How many days do you flow?_____

□ Do you have pain with your periods? Yes □ Mild □ Moderate Severe □ Painful □ Very painful □
□ Do you have any bleeding between your periods? Yes □
□ Is the flow due to period Scanty? Yes □ Moderate □ Heavy □
□ Last period started on _____
□ Was it on time? Yes □ - If not, was it early by _____ days? Delayed by _____ days?
□ Do you often skip your periods? Yes □
□ Missed your period? Yes □

Contraceptive H/O

□ Do you use Birth Control? Yes □
If yes, check type of birth control: IUD □ Diaphragms □ Pills □ Tubal □ Abstinence □
□ Do you plan to have children? Yes □
□ Are you trying to become pregnant now? Yes □
□ Male partner uses: Condoms □ had Vasectomy □ Other _____
□ Have you had any complications with pills? Yes □ With other types of birth control? Yes □

Sexual History

At what age did you first have intercourse? _____
□ Do you have any problems with sex? Yes □ If yes, explain: _____
□ Do you currently have or did you in the past have exposure to multiple partners? Yes □ : If yes, how many sexual partners do you have? _____ Male, Female, Both (circle which apply)
□ Do you have pain with intercourse? Yes □
□ Do you bleed with intercourse? Yes □
□ Have you had sex without any birth control since your last period? Yes □
Type of sexual activity: Vaginal □ Oral □ Other □ _____

GYN History

Date of last pap smear _____ □ Normal □ Abnormal

NO Last Mammogram _____ □ Normal □ Abnormal

□ Do you have a family H/O Early Breast Ca, pain in the breast, lumps? Yes □
□ Do you perform a self breast exam every month? Yes □
Have you ever had any of the following? Check all that apply

_____ Chlamydia	_____ Syphilis
_____ Gonorrhea	_____ Venereal Warts
_____ Herpes	_____ Trichomonas
_____ Hepatitis	_____ Recurrent Yeast
_____ HIV	_____ Bacterial Vaginosis

Have you experienced any of the Vaginal Symptoms recently?

NO		**Today**	**Past 2 mo.**
□	Itching	□	□
□	Unpleasant Odor	□	□
□	↑ Discharge	□	□
□	Cheesy white thick discharge	□	□
□	Thin milky gray discharge	□	□
□	Yellow/greenish discharge	□	□
□	Other Symptoms	□	□

NO		**YES**
□	Do you ever douche? (If yes, how often?) _____	□
□	Have you used over the counter yeast med. eg.,Monistat, Mycelex, Vagistat etc.	□
□	Did it relieve your symptoms?	□
□	Have you experienced emotional changes recently?	□
□	Related to your period?	□
□	Not related to your period?	□
□	Is there anything else you would like to discuss?	□

_____

_____

(Please explain "Yes" answers on lines below)

Hematological/lymphatics/Immunology

NO	YES	Current/Past	
☐ Easy bruising / bleeding	☐	☐	☐
☐ Blood transfusion	☐	☐	☐
☐ Swollen Lymph Nodes	☐	☐	☐
☐ Blood clots in the leg	☐	☐	☐
☐ Blood clots anywhere else	☐	☐	☐
☐ Auto Immune disease	☐	☐	☐
Have you had any of the following?			
☐ Rheumative Fever	☐	☐	☐
☐ Rubella	☐	☐	☐
☐ Mumps	☐	☐	☐
☐ Chicken Pox	☐	☐	☐
☐ German Measles	☐	☐	☐
Other			
☐ Cancer	☐	☐	☐
☐ Chronic Pain	☐	☐	☐
☐ Speech difficulty	☐	☐	☐
☐ Hearing Loss	☐	☐	☐
☐ Problem with Anesthesia	☐	☐	☐
Sleep Pattern			
# Pillows _____ # Hours _____			
Mood Changes	☐	☐	☐
☐ Depression	☐	☐	☐
☐ Fatigue	☐	☐	☐
☐ Panic disorder	☐	☐	☐
☐ Premenstrual mood disorders	☐	☐	☐
☐ Low Libido	☐	☐	☐

Assisted Devices

NO	YES	Current/Past	
☐ Contact Lens	☐	☐	☐
☐ Glasses	☐	☐	☐
☐ Pacemaker	☐	☐	☐
☐ Dentures	☐	☐	☐
☐ Hearing Aid	☐	☐	☐
☐ Other	☐	☐	☐
Previous Surgery			
Have you had surgery for the following?			
☐ Appendix	☐	☐	☐
☐ Gall Bladder	☐	☐	☐
☐ Breast	☐	☐	☐
☐ Thyroid	☐	☐	☐
☐ Varicose Veins	☐	☐	☐
☐ Hernia	☐	☐	☐
☐ C/Sections, Ectopic pregnancy	☐	☐	☐
☐ Tubal ligation	☐	☐	☐
☐ Hysterectomy	☐	☐	☐
☐ Ovarian Cyst	☐	☐	☐
☐ Other	☐	☐	☐

Explanation:_____
_____
_____
_____

Did you or a family Member have an Autoimmune Disease?

NO	YES	YOU / Family	
☐ Multiple Sclerosis [nerves affected, vision]	☐	☐	☐
☐ Rheumatoid Arthritis [stiffness of joints of hands, swelling]	☐	☐	☐
☐ Lupus [fatigue, rashes, joint pain]	☐	☐	☐
☐ Psoriasis [affects skin]	☐	☐	☐
☐ Scleroderma [thickening of skin,blood vessels, heartburn, toes, fingers sensitive to cold]	☐	☐	☐
☐ Guillian Barre Syndrome [tingling in legs - paralysis]	☐	☐	☐
☐ Myasthinia gravis [skeletal muscle weakness affects eye movement,chewing,talking swallowing]	☐	☐	☐
☐ Grave's Disease [overactive thyroid, bulging eyes, wt. loss, tremors]	☐	☐	☐
☐ Hashi moto's thyroiditis [affects thyroid - physical & mental slowing]	☐	☐	☐
☐ Wegener's granulomatosis [chronic cough, nosebleeds, ear congestion	☐	☐	☐

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REVIEW OF SYSTEMS

Did you in the past, or do you currently have any problems in the following areas? If "YES", provide information on lines below.

Constitutional Symptoms	NO	YES	Current/Past
Fever	☐	☐	☐
Weight loss	☐	☐	☐
↑↑ Weight gain	☐	☐	☐
Fatigue	☐	☐	☐
Pain	☐	☐	☐
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Other	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Fainting/Blackouts	☐	☐	☐
Slurred Speech	☐	☐	☐
Seizure disorder	☐	☐	☐
Stroke	☐	☐	☐
Alzheimers	☐	☐	☐
Brain Tumor	☐	☐	☐
Eyes			
Loss of vision	☐	☐	☐
Double vision	☐	☐	☐
Dryness	☐	☐	☐
Glaucoma	☐	☐	☐
Cataract	☐	☐	☐
Other	☐	☐	☐
Skin			
Rashes/color change/Eczema	☐	☐	☐
Wound	☐	☐	☐
Ulcer	☐	☐	☐
Itching or dryness	☐	☐	☐
Hair or Nail changes	☐	☐	☐
Ears / Nose / Mouth / Throat			
Hearing Difficulty	☐	☐	☐
Ringing or Vertigo	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny nose or postnasal drip	☐	☐	☐
Nosebleeds	☐	☐	☐
Dry throat / mouth / hoarseness	☐	☐	☐
Thyroid disorder	☐	☐	☐
Cardiovascular (Heart/blood vessels)			
Chest Pain	☐	☐	☐
Palpitations	☐	☐	☐
Heart Murmur	☐	☐	☐
M.V.P.	☐	☐	☐
↑ B.P.	☐	☐	☐
MI / Heart Attack	☐	☐	☐
CHF	☐	☐	☐
Leg pain	☐	☐	☐
High Cholesterol	☐	☐	☐
↑ Blood Fat (triglycerides)	☐	☐	☐

Respiratory (Lungs / Breathing)	NO	YES	Current/Past
Cough / Sputum	☐	☐	☐
Shortness of Breath	☐	☐	☐
Wheezing	☐	☐	☐
Br Asthma	☐	☐	☐
Lung Disease/TB/Pneumonia	☐	☐	☐
Gastrointestinal			
Swallowing difficulty	☐	☐	☐
Vomiting / heartburn	☐	☐	☐
Diarrhea / Constipation	☐	☐	☐
Bowel pattern	☐	☐	☐
Acid Reflux	☐	☐	☐
Peptic Ulcer	☐	☐	☐
IBS	☐	☐	☐
Other	☐	☐	☐
Digestive	☐	☐	☐
Diet - Regular/Special	☐	☐	☐
Appetite good	☐	☐	☐
Appetite poor	☐	☐	☐
Jaundice	☐	☐	☐
Hepatitis ☐A ☐B ☐C	☐	☐	☐
Blood in stools or black stool	☐	☐	☐
Gas / distension	☐	☐	☐
Genito Urinary			
Urinary frequency	☐	☐	☐
Urinary ☐pain or ☐blood	☐	☐	☐
Incontinence	☐	☐	☐
Kidney / Bladder disorder	☐	☐	☐
Stones	☐	☐	☐
Renal Insufficiency	☐	☐	☐
Swelling / edema	☐	☐	☐
Stress Incont/ leakage on cough	☐	☐	☐
Urge Incontinence (frequency)	☐	☐	☐
Neuro Muscular / Skeletal			
Bone / Neck / Jaw problem	☐	☐	☐
Low Back pain	☐	☐	☐
Numbness / Tingling	☐	☐	☐
Gait problem	☐	☐	☐
Muscle disease	☐	☐	☐
Arthritis	☐	☐	☐
Muscle pain or cramps	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Excessive thirst or hunger	☐	☐	☐
Thyroid	☐	☐	☐
Heat or cold intolerance	☐	☐	☐
Obesity	☐	☐	☐
Infertility	☐	☐	☐

Explanation:

_____

_____

_____

_____

_____