Center for Urogynecology & Female Pelvic Health
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MEDICAL HISTORY QUESTIONNAIRE

Name____ Date____________________

To help us provide you with the best medical care, please complete this form in as much detail as possible. If the form is completed prior to your office visit, please bring it to your appointment. DO NOT MAIL IT.

Please write in your own words the nature of your current medical problem. (Use other side if necessary.)

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Please fill in the following information:

Age __________

Date of birth ______________________

Number of pregnancies __________

Age when periods first started __________

Number of children born alive __________

Date of most recent menstrual period __________

Number of miscarriages __________

Number of days from the start of one period to the start of the next period __________

Number of abortions __________

Are your periods regular? Yes _____ No _____

Birth control method __________

How long do your periods last?__________

DES exposure __________

Have you gone through menopause?__________ If yes, at what age?__________

PAST MEDICAL HISTORY

As a child did you have:

__________ Rheumatic fever
__________ Scarlet fever
__________ Rubella
__________ Other _________________________

As an adult have you had:

__________ Heart disease
__________ Kidney disease
__________ Kidney infection
__________ Bladder infection
__________ Liver disease
__________ Tuberculosis
__________ Diabetes
__________ Pneumonia
__________ Asthma
__________ Jaundice
__________ High blood pressure
__________ Serious injuries or accidents

SURGICAL HISTORY

Have you had any surgeries? Yes __________ No __________

If yes, please list type and date or age:

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Have you had any blood transfusions? Yes_______ No _______ If yes, any reactions? _______ No _______

Previous Rhogam injections? Yes _______ No _______

Do you smoke? __________ If yes, how any packs per day? __________

Do you use alcohol? __________ Any street drugs? __________

Do you have any drug allergies? Yes _____ No _____ If yes, which drugs___________________________________

MEDICATIONS

Please list all medications which you are currently taking. (Include contraceptives and vitamins.)

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GYNECOLOGIC HISTORY

Please check if you have any of the following:

__________ Bleeding between periods If yes, duration ____________________

__________ Bleeding after intercourse If yes, duration ____________________

__________ Heavy menstrual periods If yes, duration ____________________

__________ Pain with periods If yes, duration ____________________

__________ Uncontrolled loss of urine with coughing or at other times If yes, how long __________________

Date of last Pap smear __________ Normal? Yes __________ No __________

Have you ever had any treatment to your cervix? Yes __________ No __________

__________ Cautery __________ Other __________________

__________ Cryosurgery If yes, when _______________________

Have you had any infection in your female organs? Yes ____ No ____ If yes, when _____________________

Have you ever had a sexually transmitted disease (STD)? Yes ___ No ___ If yes, when ___________________

Have you ever had herpes? Yes __________ No __________ or venereal warts? Yes __________ No __________

Are you sexually active at this time? Yes ___ No ____ Is your sex life satisfactory for you? Yes ____ No ____

Do you have any questions about sex you would like to ask? Yes __________ No __________

FAMILY HISTORY

Has anyone in your family had any of these diseases? If so, please give relationship.

High blood pressure__________________________ Diabetes_________________________________

Stroke _____________________________________ Breast cancer____________________________

Heart disease _______________________________ Other cancer ____________________________

List any other diseases____

SOCIAL HISTORY

Current marital status: Married ______ Single ______ Divorced ______ Widowed ______ Separated ______

Number of people in your household _______

Your occupation __________________________ Your spouse's occupation _______________________________

HEALTH HABITS

How many hours do you sleep at night? __________

Do you eat regular meals including breakfast? _________

Do you eat whole grain bread and cereal, fresh fruits and vegetables daily? _____ Do you exercise regularly?_____

If yes, what type of exercise do you do? __________________________ How often do you exercise? ____________

What do you do to relax? ______________________ Do you consider yourself healthy? _____________

REVIEW OF SYSTEMS
Please check if you have recently experienced any of the following:

_________ Fever
_________ Sweating at night
_________ Skin rashes
_________ Skin infections
_________ Change in any mole
_________ Severe headaches
_________Dizziness
_________ Ear pain
_________ Ear infections
_________ Ear discharge
_________ Ringing in ears
_________ Decreased hearing
_________ Breast pain
_________ Breast lumps
_________ Nipple discharge
_________ Breast size change
_________ Breast x-rays
_________ Asthma
_________ Chest x-ray. If so, date _________
_________ Chest pain
_________ Fainting
_________ Swelling of legs
_________ Varicose veins
_________ Blood clots
_________ Heart murmur
_________ Pain in legs with exercise
_________ Joint pain
_________ Hernia
_________ Difficult food digestion
_________ Joint swelling
_________ Change in bowel habits
_________ Stroke
_________ Intolerance to heat
_________ Excessive urination
_________ Excessive water drinking
_________ Excessive eating
_________ Psychiatric treatment
_________ Weakness
_________ Fatigue
_________ Recent weight loss
_________ Recent weight gain

_________ Change in appetite
_________ Loss of hair
_________ Low blood count (anemia)
_________ Easy bruising
_________ Prolonged bleeding
_________ Gland enlargement in neck, axilla or groin
__________Frequent bloody noses
_________ Sores in mouth
_________ Bleeding gums
_________ False teeth
_________ Hoarseness
________ Sinus infections
_________ Throat infections
_________ Cough
_________ Coughing up blood
________ Sputum
_________ Difficulty breathing
_________ with laying down
_________ with exercise
_________ during sleep
_________ Nausea
_________ Vomiting
_________ Constipation
_________ Vomiting blood
_________ Difficulty swallowing
_________ Vomiting blood
_________ Floating stools
_________ Diarrhea
_________ Hemorrhoids
_________convulsions
_________ Enlarged thyroid

_________ Difficulty speaking
_________ Nervousness
_________ Tremors
_________ Difficulty walking
_________ Depression
_________ Thoughts of suicide
_________ Itching
_________ Other ____________________________