MEDICAL HISTORY QUESTIONNAIRE

Name: _____ DOB: _____

Reason for visit: _____

Date of last pap smear: _____ Results: _____

History of abnormal pap: Yes _____ When: _____ Result: _____ No_____

Problems with breast: Yes_____ No_____ Birth control name: _____

First day of last period: _____ Hysterectomy: _____ When: _____ Age at first period: _____

How is your menstrual flow: Light_____ Moderate_____ Heavy_____ How many days_____

Cramps with cycle: Yes_____ No_____ Do you have PMS: Yes _____ No _____

Bleeding between cycles: Yes____ No ____ Bleeding with intercourse: Yes ___ No___

Problems with urination or vaginal discharge: Yes_____ No _____

History of STD: Yes_____ No _____

Number of Pregnancies _____ C-section _____

Smoker: Yes _____ No _____ Past smoker when did you stop _____

Alcohol: Yes _____ No _____ Social drugs: Yes _____ No _____

Hospitalizations: _____

Surgeries: _____

History of any psychological conditions: _____

History of any other medical conditions: _____

ALLERGIES TO MEDICATIONS_____

LIST ALL MEDICATIONS TAKEN ON A REGULAR BASIS INCLUDING OVER THE COUNTER_____

_____

Date of last: Annual Physical _____ Mammogram: _____

Bone Density _____ Colonoscopy _____ Glucose _____ Cholesterol _____

Dental exam_____ Eye exam _____

CONTINUED ON BACK SIDE

Immunizations/Vaccines: Tetanus _____ Flu _____ Pneumonia _____ Shingles _____

Hepatitis A _____ Hepatitis B _____ HPV(Gardasil) _____ Meningitis _____

Family History: Breast cancer_____ Uterine cancer_____ Ovarian cancer_____

Colon cancer _____ Diabetes_____ Heart disease ____ High blood pressure_____

Stroke ____ Thyroid disease _____ Autoimmune _____ Osteoporosis_____

Other _____

Do you have an advanced directive: Yes _____ No _____