PATIENT HISTORY QUESIONAIRE

NAME:_____ DATE OF BIRTH:_____

Past Obstetrical History

- ☐ Large Infants
- ☐ Miscarriages
- ☐ Breech
- ☐ Cervical Incompetence
- ☐ Cesarean Section
- ☐ Gestational Diabetes
- ☐ Ectopic Pregnancy
- ☐ Fetal Abnormality
- ☐ Hypertension in Pregnancy
- ☐ Placental Abruption
- ☐ Placenta Previa
- ☐ Pre-Eclampsia
- ☐ Premature labor or delivery
- ☐ Small for dates infant
- ☐ Twin or multiple pregnancy
- ☐ Other_____

Gynecological History

- ☐ Abnormal pap smear
- ☐ No periods or infrequent periods
- ☐ Painful periods
- ☐ Painful intercourse
- ☐ Endometriosis
- ☐ Heavy periods
- ☐ Infertility
- ☐ Uterine fibroids
- ☐ Any sexually transmitted disease
- ☐ Irregular periods
- ☐ Menopausal Disorders
- ☐ Pelvic inflammatory disease
- ☐ Polycystic ovaries
- ☐ Postmenopausal bleeding
- ☐ PMS
- ☐ Other_____

Breast

- ☐ Abnormal mammogram
- ☐ Breast abscess
- ☐ Any breast disorder
- ☐ Breast cancer
- ☐ Milk or discharge from breast
- ☐ Any breast mass or cyst
- ☐ Other_____

Cardiovascular

- ☐ Atrial fibrillation
- ☐ Hypertension
- ☐ Cardiomyopathy
- ☐ Cardiovascular disease
- ☐ Coronary artery disease
- ☐ Mitral valve disorder
- ☐ Heart disease
- ☐ Peripheral vascular disease
- ☐ Pulmonary embolism
- ☐ Rheumatic heart disease
- ☐ Other_____

Digestive Disorders

- ☐ Anal fissures
- ☐ Anal abscess
- ☐ Celiac disease
- ☐ Ulcers
- ☐ Colon cancer
- ☐ Diverticula
- ☐ Esophageal refux (GERD)
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disorder
- ☐ Other_____

Endocrine

- [ ] Diabetes Type I
- [ ] Diabetes Type II
- [ ] High cholesterol or lipids
- [ ] Hypothyroidism
- [ ] Hyperthyroidism
- [ ] Other_____

Urology

- [ ] Kidney stones
- [ ] Chronic urinary infections
- [ ] Kidney infections
- [ ] Renal failure
- [ ] Incontinence
- [ ] Other_____

Hematologic

- [ ] Blood clots
- [ ] Anemia
- [ ] Coagulation disorders
- [ ] Sickle cell trait or anemia
- [ ] Thalassemia
- [ ] Von Willebrand's disease
- [ ] Other_____

Cancers or Malignancies

- [ ] Any personal history of any cancers or malignancies

_____

_____

_____

Neurologic

- [ ] Fibromyalgia
- [ ] Migraines with aura
- [ ] Migraines without aura
- [ ] Other_____

Psychiatric

- [ ] Anxiety
- [ ] Depression
- [ ] Other_____

Respiratory

- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Other_____

NAME:_____ DATE OF BIRTH:_____

PAST SURGICAL HISTORY

Date	Reason for Operation and Findings	Organ or Tissue Removed	Hospital and Location

List medications currently being taken:

_____

_____

_____

Allergies to any medications, foods or environmental:

_____

_____

_____

FAMILY MEDICAL HISTORY

	Age	Living	Deceased	Cause
Mother	____	_____	_____	_____
Father	____	_____	_____	_____
Number of Sisters		_____	_____	_____
Number of Brothers		_____	_____	_____

REPRODUCTIVE HISTORY

_____ Age at menarche
_____ Number of days between cycles
_____ Number of days of bleeding with period
_____ Menstrual Flow (heavy, normal, light)
_____ Number of tampons used per day
_____ Number of pads used per day
_____ First day of last menstrual period
_____ How certain are you of the date of your last period?
_____ If menopausal, the age when you had your last period?
_____ Method of birth control

PREGNANCY HISTORY

_____ Total pregnancies
_____ Full term
_____ Premature deliveries
_____ Elective abortions
_____ Miscarriages
_____ Ectopics
_____ Multiples
_____ Living children
_____ Cesarean sections
_____ Any complications with any of your pregnancies

SOCIAL HISTORY

_____ Do you drink alcohol?
If yes:
_____ How often do you drink?
_____ How much do you drink?
_____ What age did you start drinking?

_____ Do you smoke tobacco or use tobacco products?
If yes:
_____ How often?
_____ How much?
_____ What age did you start?

_____ Do you use any illegal drugs or abuse prescription drugs?
If yes:
_____ What drugs do you take?
_____ How much?
_____ How often?

_____ Do you exercise?
If yes:
_____ How often do you exercise?
_____ What form of exercise?

_____ Have you experienced any physical, emotional or sexual abuse?
_____ Do you feel safe at home?
_____ Do you have sex with men, women or both?

REVIEW OF SYSTEMS

NAME:_____ DATE OF BIRTH:_____

Please mark any items you are experiencing today:

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Loss of Appetite
- ☐ Other:_____

BREASTS
- ☐ Lumps
- ☐ Tenderness
- ☐ Swelling
- ☐ Redness
- ☐ Nipple Discharge
- ☐ Abnormal changes in breasts
- ☐ Other:_____

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irrgeular heart rate
- ☐ Rapid heart rate
- ☐ Fainting/passing out
- ☐ Lightheadedness
- ☐ Other:_____

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Other:_____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Suicidal or homicidal thoughts
- ☐ Other:_____

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Other:_____

GENITOURINARY
- ☐ Urgency
- ☐ Frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Decreased libido
- ☐ Painful intercourse
- ☐ Irregulary periods
- ☐ Painful periods
- ☐ Very heavy periods
- ☐ Vaginal Discharge
- ☐ Bleeding after sex
- ☐ Infrequent or no periods
- ☐ Possible pregnancy
- ☐ Significant PMS
- ☐ Other:_____

ENDOCRINE
- ☐ Nipple discharge
- ☐ Loss of hair
- ☐ Acne
- ☐ Abnormal hair growth
- ☐ Other:_____