

OBSTETRICAL & GYNECOLOGICAL ASSOCIATES, P.L.C.

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HEALTH QUESTIONNAIRE

Date _____

I. Name: _____ Age: _____ Date of Birth: _____

II. MENSTRUAL AND OBSTETRICAL HISTORY:

Age at onset of periods _____ Interval between periods (days) _____ Duration of period (days) _____

Pain: Severe _____ Moderate _____ Mild _____ None _____
Menstrual flow: Heavy _____ Normal _____ Light _____
Date of last period: _____

Number of vaginal deliveries _____ Number of c-sections _____ Number of miscarriages _____ Number of terminations _____ pregnancy

Date of last pap smear _____ Normal _____ Abnormal _____

Have you had abnormal bleeding during the past year? Yes _____ No _____ If yes, please explain: _____

III. List medications (drugs) currently being taken:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Present Method of Contraception (if any) _____

IV. PAST HISTORY:

1. Allergies (especially drugs) _____

2. Operations:

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

3. Illness or Diseases if any: (Diabetes, hypertension, rheumatic fever, thyroid, etc.)

PLEASE COMPLETE OTHER SIDE!

PATIENT QUESTIONNAIRE (Cont.)

	Yes	Answer or	No
V. SYSTEM REVIEW: Do You Have or Have You Ever Had:			
a.) Blood in urine or change in your urinary habits.	_____		_____
b.) Vomiting of blood, stomach ulcer, blood in your bowel movements or changes in their color, caliber or consistency.	_____		_____
c.) Previous heart or lung disease, coughing up blood or shortness of breath with normal activity.	_____		_____
d.) Emotional or mental disorder requiring medical treatment and/or hospitalization.	_____		_____
e.) Weight change of 10 pounds or more during the past year.	_____		_____
f.) Do you use tobacco and if so quantity _____			
g.) Do you use alcohol and if so quantity _____			
h.) Drug or alcohol abuse requiring hospitalization _____			

VI. FAMILY HISTORY: (If Deceased include Age at Death and Cause if Known)

	<u>Age</u>	<u>Living</u>	<u>Deceased</u>	<u>Cause</u>
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Number of Sisters	_____	_____	_____	_____
Number of Brothers	_____	_____	_____	_____

VII. List any diseases (breast, lung, bowel cancer, etc.) that seem to repeatedly occur in your family—including aunts, uncles and grandparents.

VIII. Date of: a.) Last medical examination _____ Pelvic exam _____

b.) Chest X-ray _____

IX. State any additional comments about your Medical History:

X. Reason for Office Visit: (state briefly any specific problems)
