CONFIDENTIAL PATIENT MEDICAL HISTORY QUESTIONNAIRE

PRINT NAME _____ **DOB** _____

REASON FOR VISIT_____

ALLERGIES (please specify)_____

Current Medications: (Name, dose and reason for taking)

_____

_____

_____

_____

PAST MEDICAL AND FAMILY HISTORY

Please check ✔ if you (self) or any blood relative (family) had any of the following conditions.

Medical History:	Self	Family		Self	Family
Headache/Migraine	___	___	Liver Disease	___	___
Seizure Disorder	___	___	Colon Disease	___	___
Thyroid Disease	___	___	Kidney Disease	___	___
Wt. Loss/Gain	___	___	Urinary Infections	___	___
Heart Disease	___	___	Urinary Incontinence	___	___
High Blood Pressure	___	___	Anemia/Blood Disorder	___	___
Lung Disease	___	___	Blood Transfusions	___	___
High Cholesterol	___	___	Varicose veins/Phlebitis	___	___
Diabetes	___	___	Osteoporosis	___	___
Breast Cancer	___	___	Anxiety/Depression	___	___
Acid Reflux	___	___	Cancer (Specify Type)		
Peptic Ulcer (Stomach)	___	___	Colon	___	___
HIV/AIDS	___	___	Ovarian	___	___
Hep B	___	___	Uterine	___	___
Hep C	___	___	Endometrial	___	___

If yes, please use the lines below to describe type of illness, date of diagnosis and treatment.

_____

_____

_____

Have you ever been treated for MRSA (Methicillin-Resistant Staphylococcus Aureus)?
If yes, when contracted, place of exposure, treated by whom? (Please explain)

_____

_____

_____

Gynecologic History:
Please list below the date, name and reason for any procedure done on your cervix, uterus or ovaries including abnormal Pap Smears.

_____

_____

_____

PRINT NAME _____ **DOB** _____

Menstrual History:

			Yes	No
Age at 1st period	_____	Pain with periods?	___	___
Date of last period	_____	Medication for menstrual pain?	___	___
How often do you have a period?	_____	Bleeding/spotting between periods?	___	___
How long does your period last?	_____	Describe _____		
How many periods in the last year?	_____	Bleeding/spotting after intercourse?	___	___
		Describe _____		

Date of menopause _____

Symptoms with menopause _____

Treatment for menopausal symptoms _____

Date of last mammogram _____ Result _____

Do you have a personal history of any breast problems? Yes ___ No ___

If yes, please describe _____

_____

Date of last pap smear _____ Result _____

Please describe your current method of contraception. If a pill, please include name.

_____

	YES	NO
Do you have a history of vaginal infections?	___	___
Yeast	___	___
Bacterial Vaginosis	___	___
Trichomonas	___	___
Chlamydia	___	___
Herpes	___	___
Gonnorrhea	___	___
Genital Warts	___	___

If yes, please explain _____

_____

SEXUAL HISTORY

Have you ever had vaginal intercourse (sex)?	___	___
Have you recently had sex with a new partner?	___	___
Have you ever had intercourse against your will?	___	___
Have you previously or currently been abused by your partner?	___	___
Are you sexually active now?		
If yes, was your last partner	Male _____	Female _____
Number of lifetime partners?	_____	

SOCIAL HISTORY	**YES**	**NO**		
Do you SMOKE?	___	___	If yes, how much daily?_____	How many years? Quit? __
Do you drink ALCOHOL?	___	___	If yes, how much? _____	How often? _____
Do you use street DRUGS?	___	___	If yes, what type? _____	How often? _____
Do you use CAFFEINE?	___	___	If yes, what type? _____	How much daily? _____
Do you exercise?	___	___	If yes, how often? _____	How long at a time? _____
Do you take Folic Acid	___	___	If yes, how often? _____	How much at a time? _____

PRINT NAME _____ **DOB** _____

PAST HOSPITALIZATIONS
Please list date and reason for any overnight stay in the hospital, excluding the birth of a child.

_____

_____

_____

_____

_____

_____

PAST SURGERIES
Please list the date and name of the procedure and reason for any surgeries not listed above.

_____

_____

_____

_____

_____

OBSTETRIC HISTORY
Please fill in the number of:

Pregnancies _____
Premature births _____
Miscarriages _____
Abortions _____
Living children _____

For each pregnancy please fill in:

Date of Birth Weeks Pregnant at Delivery Birth weight Sex Type of Delivery

_____

_____

_____

_____

_____

Physician_____ **Date** _____

Note: Confidential documents are absolutely held to the highest degree of ethical and legal status. This medical facility rigidly complies in strict accordance with the laws and regulations of the State of Illinois and/or federal confidentiality legislation designed to protect the rights of the patient.

Signature _____ **Date** _____