

**CONFIDENTIAL PATIENT MEDICAL HISTORY QUESTIONNAIRE**

**PRINT NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**REASON FOR VISIT** \_\_\_\_\_

**ALLERGIES (please specify)** \_\_\_\_\_

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

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**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	___	___
			Ovarian	___	___
			Uterine	___	___
			Endometrial	___	___

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

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Have you ever been treated for MRSA (Methicillin-Resistant Staphylococcus Aureus)?

If yes, when contracted, place of exposure, treated by whom? (Please explain)

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**Gynecologic History:**

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

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**PRINT NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Menstrual History:**

**Yes No**

Age at 1 <sup>st</sup> 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.

	<b>YES</b>	<b>NO</b>
Do you have a history of vaginal infections?	___	___
Yeast	___	___
Bacterial Vaginosis	___	___
Trichomonas	___	___
Chlamydia	___	___
Herpes	___	___
Gonorrhea	___	___
Genital Warts	___	___
HIV/AIDS	___	___

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.

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**PAST SURGERIES**

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

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**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

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**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** \_\_\_\_\_