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MEDICAL HISTORY INTAKE QUESTIONNAIRE

Name: _____ Date: ____/____/____

Date of Birth:___/____/_____ Height:_____ Weight: _____ Gender:_____

What brings you to our office today:

_____

_____

PERSONAL PROFILE (Please circle when appropriate)

Marital Status: single dating engaged married widowed divorced

Number of living children: _____

Number of people in household: _____

Highest Education level completed: grade school high school college graduate degree other

Current Job/work: _____ Place of work:_____

Please list all ACTIVE treating physicians (i.e. ob/gyn, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty:_____

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MEDICATIONS & SUPPLEMENTS

Please list ALL medications, including over the counter and prescribed. Please be thorough. Add additional sheets if necessary.

Medication Name	Dose	How often taken	Reason for taking

Last Name_____ **CENTER FOR ADVANCED GYNECOLOGY**

ALLERGIES

Drug, Environmental, or Food Allergy	Reaction

OBSTETRICAL HISTORY

#____ Pregnancies

#____ Full term (37+ weeks)

#____ Premature

#____ Miscarriage

#____ Abortion

#____ Living children

Where there any complications during pregnancy, labor, delivery, or post-partum?

C-Section (#____) Vacuum Forceps Episiotomy

"3rd or 4th degree" tear Heavy Bleeding after delivery Other:

GYN HISTORY

How old were you when your menses started? _____

Are you still having menstrual periods? Yes No

Answer the following only if you are still having menstrual periods.

First day of your last menstrual period? ____/____/____

How many days between your periods? _____

How many days of menstrual flow? _____

Periods are: Light Moderate Heavy Bleed through protection

Are your periods regular? Yes No

Do you have any pain with periods? Yes No

When was your last pap smear/HPV testing? _____ Normal Abnormal

Have you ever had an abnormal pap? Yes No

If yes, when? _____

What was the abnormality? _____

Have you ever had the following:

☐ Colposcopy - Date:_____ ☐ LEEP - Date: _____

☐ Cryosurgery (Freezing) - Date: _____ ☐ Other - Date: _____

Did you have the full course of HPV Vaccine? Yes No

Do you prefer: men women both neither

Have you ever had: (Please circle all that apply)

trichomonas genital herpes chlamydia gonorrhea pelvic inflammatory disease (PID)

Birth control method: (please circle)

Condom	Depo provera	Hysterectomy	IUD	Nexplanon
Pill	Post-menopausal	Tubal Sterilization	Vaginal ring	Vasectomy
None	Other _____			

If you have had a mammogram, when was the last? ___/___/____ result: normal abnormal

Do you currently or in the past have you had:

Endometriosis	yes	no
Fibroids	yes	no
Infertility	yes	no
Ovarian Cysts	yes	no
PCOS	yes	no

FAMILY HISTORY: Please circle those that apply & list family member (e.g. mother)

Depression	Diabetes	Drinking/Drug Problem
Deep Venous Thrombosis(DVT)	Endometriosis	Heart Disease
Hypertension	Pulmonary Embolism	Stroke
Breast Cancer	Ovarian Cancer	Colon Cancer
Endometrial Cancer	Other cancer (e.g. prostate)_____	

Other please specify:_____

I AM ADOPTED

HEALTH HABITS

Exercise? Rarely 1-2 times weekly 3-5 times weekly Daily

Caffeine intake (# cups per day, include coffee, tea, soft drinks, etc)?

0 1-3 4-6 >6

Tobacco use: Yes No # packs/day: ____ Age started: _____ Age quit: _____

Alcohol use: Yes No # drinks per week: ____

Have you ever received treatment for substance abuse? Yes No

What is your use of recreational drugs?

Never used Past use Presently using No answer

Heroin Amphetamines Marijuana Barbiturates Cocaine Other_____

Last Name_____ **CENTER FOR ADVANCED GYNECOLOGY**

Personal Safety

Has anyone close to you ever threatened or hurt you?	Yes	No
Has anyone ever hit, kicked, choked, or hurt you physically?	Yes	No
Has anyone, including your partner, ever forced you to have sex?	Yes	No
Are you ever afraid of your partner?	Yes	No

OPERATIONS / HOSPITALIZATIONS

Year	Procedure or Hospitalization Reason	(Surgeon)

PAST MEDICAL HISTORY Please circle all that apply

Alzheimer's/Other Dementias	Y	N	Crohn's Disease/ Ulcerative Colitis	Y	N	Irritable Bowel Syndrome	Y	N
Anemia	Y	N	Depression	Y	N	Kidney Disease	Y	N
Anxiety Disorders	Y	N	Diabetes	Y	N	Lung Disease (including COPD)	Y	N
Arthritis	Y	N	Digestive Disorders	Y	N	Memory Loss	Y	N
Asthma	Y	N	Epilepsy/ Seizures	Y	N	Menopause	Y	N
Back Pain	Y	N	Eye Disease	Y	N	Osteoporosis	Y	N
Blood Pressure, High	Y	N	Fibromyalgia	Y	N	Pulmonary Embolism/DVT	Y	N
Breast Cancer	Y	N	Headache	Y	N	Sleep Apnea	Y	N
Cholesterol, High	Y	N	HIV/ AIDS	Y	N	Stroke	Y	N
Colon Cancer	Y	N	Insomnia	Y	N	Thyroid Disorders	Y	N
Congestive Heart Failure	Y	N	Interstitial Cystitis	Y	N	Urine or Bladder Problem	Y	N

Other Conditions not listed above: _____

Completed by: ☐ Patient ☐ Nurse ☐ Physician

Signature of Patient _____