THE FEMALE PELVIC HEALTH CENTER
MEDICAL HISTORY QUESTIONNAIRE

Name	Date of Birth	Age	Drug Allergies
Please describe the reason for your visit (chief complaint)			

OBSTETRIC HISTORY

Number of Pregnancies	Number of Vaginal Deliveries:	Number of Cesarean Deliveries
Forceps or vacuum? ☐ Y ☐ N	Episiotomy? ☐ Y ☐ N	Laceration/tear? ☐ Y ☐ N Degree? 1 2 3 4
Largest baby (wt)	Other complications? Prolonged labor?	

GYNECOLOGIC HISTORY

Date of last menstrual period:	Do you experience any of the following? (check ones you have)
Date of last PAP smear: Normal?	_____ Bleeding between periods _____ Heavy menstrual periods
Date of last mammogram: Normal?	_____ Pain with periods
Have you ever had a sexually transmitted disease? If yes, when?	_____ Bleeding after intercourse _____ Pain with intercourse
Are you sexually active at the present time?	_____ "Falling" of pelvic organs or prolapse
Are you using contraception? If yes, what type?	Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	**Name of Medication**	**Dosage** **How often you take it**	**How long have you been** **on the medication**
Example - Hypertension	*Tenormin*	*50mg 1 daily*	*2 years*

Reviewed with Patient ____________/____/____
Drs Initials & Date

Name	DOB	Date

PAST SURGICAL AND HOSPITAL HISTORY: ☐ None ☐ Yes, if yes

Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?
Please circle **Y** or **N** for each condition (no blanks please ☺)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
Y	N	High blood pressure	Y	N	Heart disease	Y	N	Thyroid disease
Y	N	Stroke	Y	N	Diabetes	Y	N	Asthma
Y	N	Kidney disease	Y	N	Liver disease	Y	N	Breast disease
Y	N	Cancer (indicate type)						
Y	N	Other						

SOCIAL HISTORY

Marital Status	Drug/Alcohol Use: Yes No	Tobacco Use: Yes No
Single Married Widowed Separated Divorced	Drinks/week	Cigarettes/day

Highest Level of Education	Employment (please include job title)

Race

Caucasian African American Hispanic Asian American Other

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?
Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight change	Y	N	Fatigue	Y	N			
Eyes:	Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
Ears/Nose/Mouth/Throat:	Ulcers	Y	N	URI	Y	N			
Cardiovascular:	Chest pain	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
Respiratory:	SOB (short of breath)	Y	N	Wheezing	Y	N			
Gastrointestinal:	Nausea/Vomiting	Y	N	Diarrhea	Y	N	Bloody Stool	Y	N
Musculoskeletal:	Weakness	Y	N						
Integumentary/Skin:	Rash	Y	N						
Neurological:	Seizure	Y	N	Syncope (fainting)	Y	N	Neuropathy	Y	N
Psychiatric:	Depression	Y	N	Anxiety	Y	N			
Endocrine:	Hot flashes	Y	N	Diabetes	Y	N	Thyroid	Y	N
Hematologic/Lymphatic:	Easy bruising	Y	N	Bleeding	Y	N	Adenopathy (Swollen Glands)	Y	N
Allergic/Immunologic:	Seasonal	Y	N	Animal Dander / Foods	Y	N			
Other:									

______________________________ Patient Signature

______________________________ Date

Reviewed with Patient ____________/______/_______