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Lily ob/gyn

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **DOB:**_____ **Age** _____

Marital Status __**Single** __ **Married** __**Divorced** __**Widowed**

Preferred Pharmacy _____ **Reason for visit** _____

Primary Care Doctor/Referring Physician _____

List all medications/vitamins that you are taking (please include dose):

_____ **Dosage** _____ _____ **Dosage** _____

_____ **Dosage** _____ _____ **Dosage** _____

Which prescriptions do you need refilled today? _____

List all medications you are ALLERGIC to: _____

MENSTRUAL HISTORY (even if postmenopausal or no longer having periods)

What is your LMP (Last menstrual period)?_____ **Menopausal** __**Y** __ **N**

Age at first period: _____ **years.**

If your menstrual periods are regular; periods start every: _____ **days**

If your menstrual periods are irregular; periods start every: ____ **to** ____ **days**

Duration of bleeding: _____ **days**

Does bleeding or spotting occur between periods? ___ **Yes** ___ **No**

Does bleeding or spotting occur after intercourse? ___ **Yes** ___ **No**

Is pain associated with periods? ___ **Yes** ___ **No**

BIRTH CONTROL HISTORY

Abstinence _____

What birth control method(s) do you currently use? _____

PREGNANCY HISTORY **Have never been pregnant _____**

Number of Pregnancies _____ **Number of Deliveries _____**

Vaginal _____ **C/S _____** **Number of Living Children _____**

Number of Miscarriages _____ **Number of Abortions _____**

Any complications of pregnancy or delivery _____

PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES **None _____**

Procedure	Date	Surgeon
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY (Not OB/GYN) **None _____**

Procedure	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAP SMEAR/MAMMOGRAM HISTORY

Date of last pap smear: _____ **What were the results of this pap smear? _____**

Have you had abnormal pap smears? ___Yes ___No

Have you had treatment for abnormal pap smears? ___ Yes ___ No

What type of treatment(s) have you had? _____ **Date _____**

Date of last mammogram (if over 40): _____

Have you had an abnormal mammogram? ___ Yes ___ No

OTHER PAST GYNECOLOGICAL HISTORY Check any that apply **None _____**

_____ Vaginal infections **_____ Yeast infections** **_____ Genital Herpes**
_____ Condyloma/Warts **_____ Chlamydia** **_____ Gonorrhea**
_____ Pelvic Pain **_____ Ovarian Cysts** **_____ Polycystic Ovaries**
_____ Endometriosis **_____ Infertility** **_____ Fibroids**
_____ Ovarian Cancer **_____ Uterine Cancer** **_____ Breast Cancer**
_____ Pelvic inflammatory disease

Social Hystory Do you currently?

Work _____ No _____ Yes If yes, what is your occupation? _____

Smoke _____ Yes _____ packs/day _____ No Have you ever? _____ No _____ Yes

Drink Alcohol _____ No _____ Yes _____ wine (glasses/day); _____ beer (glasses/day)
_____ hard liquor (oz/day)

Use illicit drugs_____ No _____ Yes _____ type _____ amount

PAST MEDICAL HISTORY (check if currently treated or have been treated) None _____

_____ Anxiety **_____ Asthma** **_____ Arthritis** **_____ Diabetes**
_____ Depression **_____ Blood Clots** **_____ Thyroid problem** **_____ Heart Disease**
_____ Reflux/GERD **_____ Seizures** **_____ Breast Cancer** **_____ Colon Ca**
_____ Migraines **_____ Eating Disorder** **_____ Stroke** **_____Osteoporosis**
_____ Osteopenia **_____ Gallstones** **_____ Diverticulosis** **_____ Irritable Bowel**
_____ High Cholesterol **_____ Kidney problem** **_____ Hepatitis**
_____Other_(please list any medical problems)

FAMILY HISTORY

_____ Diabetes **___ Heart Disease** **_____ Breast Cancer** **_____ Ovarian Cancer**
_____ Endometrial Ca. **___ Colon Cancer** **_____ High cholesterol** **_____ Other**

If yes to any, please list affected relatives _____

OTHER SYMPTOMS Have you had recent had?

_____ weight loss **_____ hair growth** **_____ weight gain**
_____ hair loss **_____ change in energy** **_____ hot flashes**
_____ breast discharge/lump/pain **_____ difficult sleeping** **_____ vaginal dryness**
_____ change in urinary function **_____ other**

IF YOU ARE PREGNANT OR PLANNING TO BE PREGNANT IN THE NEAR FUTURE

Have you or the baby's father or anyone in your families ever had any of the following:

____	**Down Syndrome?**	**If yes, who? _____**
____	**Other Chromosomal abnormality?**	**If yes, who? _____**
____	**Neural tube defect (spina bifida)?**	**If yes, who? _____**
____	**Hemophilia or other coagulation problem?**	**If yes, who? _____**
____	**Cystic Fibrosis?**	**If yes, who_____**
____	**Muscular Dystrophy?**	**If yes, who? _____**
____	**Heart malformation?**	**If yes, who? _____**
____	**Sickle cell disease?**	**If yes, who? _____**
____	**Thalessemia?**	**If yes, who? _____**

_____ **_____**

Signature of Patient **Date**