Atlanta *minimally invasive* Gynecologic Surgery Center
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ADULT MEDICAL HISTORY QUESTIONNAIRE

Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific dates.
All questions contained in this questionnaire are optional and will be kept strictly confidential.

Date: _____ **Age:** _____

How would you rate your general health? □ Excellent □Good □Fair □Poor

Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Occupation: _____ Employer: _____

Years of Education/Highest Degree: _____

PERSONAL HEALTH HISTORY

Childhood Illness: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever
□ Polio □ Hepatitis A □ Hepatitis B

Immunizations and Most Recent Dates: □ Influenza □ Measles □ Tetanus □ Rubella
□ Hepatitis A □ Hepatitis B □Other:

Surgeries:

Year		Year	
Reason		Reason	
Hospital		Hospital	

Other Hospitalizations:

Year		Year	
Reason		Reason	
Hospital		Hospital	

List Your Prescribed Drugs and Over-the-Counter Drugs, such as Vitamins and Inhalers: (continue on back if needed)

Name of Drug	Strength	Frequency Taken
Have you ever had a blood transfusion?	□Yes □No	Date:

Personal / Family Health History

Have you or any relative ever had?

Cancer (check type) □ colon □ ovarian □ uterine □ breast Who?

	Patient		Relative		
Tuberculosis	□Yes	□ No	□Yes	□ No	Who?
Diabetes	□Yes	□ No	□Yes	□ No	Who?
Heart disease	□Yes	□ No	□Yes	□ No	Who?
High blood pressure	□Yes	□ No	□Yes	□ No	Who?
Stroke	□Yes	□ No	□Yes	□ No	Who?
Epilepsy	□Yes	□ No	□Yes	□ No	Who?
Suicide	□Yes	□ No	□Yes	□ No	Who?
Mental illness	□Yes	□ No	□Yes	□ No	Who?
Hysterectomy	□Yes	□ No	□Yes	□ No	Who?
Cesarean section	□Yes	□ No	□Yes	□ No	Who?
Kidney	□Yes	□ No	□Yes	□ No	Who?
Other	□Yes	□ No	□Yes	□ No	Who?

Allergies

HEALTH HABITS AND PERSONAL SAFETY

Exercise: What kind of exercise? _____ If you do not exercise, why? _____	□ Sedentary (No exercise)	□ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)	□ Occasional Vigorous Exercise
Diet: How do you rate your diet? □Good □Fair □Poor	Do you take supplements? □Yes □No	Do you drink 4 large glasses of milk daily or take calcium supplements? □Yes □ No	# of meals you eat in an average day?
Caffeine: □None □ Coffee: _____ cups/day □ Tea: _____ cups/day □ Cola: _____ /day □ Chocolate: _____ oz./day	Alcohol: Do you drink alcohol? □Yes □ No If yes, what kind? How many drinks per week? _____ Is your alcohol use a concern for you or others? □Yes □ No	Tobacco: Do you use tobacco? □Yes □No or Year Quit _____ If yes: □ cigarettes Packs/day_____ # of Years _____ □ snuff times/day_____ # of Years _____ □ chew times/day_____ # of Years _____	
Drugs: Do you currently use recreational or street drugs? □Yes □No What kind? _____	Have you ever given yourself street drugs with a needle? □Yes □ No		

GYN History

Sex: Are you sexually active? □Yes □ No	Current sex partner (s) is/are: □ Male □ Female	Birth control method: □Yes □ No □None needed	Date of last pap and pelvic exam? _____	#of pregnancies _____ # of live births _____
Date of last menstruation: _____/_____/_____	Period every _____ days.	Age at onset of menstruation: _____		
Heavy periods, irregularity, spotting, pain or discharge?	□Yes □ No			
Are you interested in being screened for sexually transmitted diseases?	□Yes □ No			
Have you ever had any sexually transmitted diseases (STDs)?		Type:	Type:	Type:
If yes, list type of STD and date:		Date:	Date:	Date:
Experienced any recent breast tenderness, lumps or nipple discharge?	□Yes □ No			
Do you have menstrual tension, pain, bloating, irritability or other symptoms around time of period?	□Yes □ No			
Any hot flashes or sweating at night?	□Yes □ No			
Any problems with control of urination?	□Yes □ No			
Any urinary tract, bladder or kidney infections within the last year?	□Yes □ No			
Any blood in your urine?	□Yes □ No			
Have you had a D&C, hysterectomy or cesarean?	□Yes □ No			
Are you pregnant or breastfeeding?	□Yes □ No			
Recent Changes In	□Weight	□Energy Level	□Ability to Sleep	□Other Pain/Discomfort: