JOSE M. MEDRANO, M.D. Ob/Gyn
2211 W. Magnolia Blvd., Suite 250, Burbank, CA 91506 • Tel: (818) 566-1490 • Fax: (818) 566-1495

Patient Questionnaire

Date:			
Name:		D.O.B.:	Email:
Gender: M / F	Race:	Ethnicity:	Preferred Language:
Reason for Visit:			
Pharmacy Name:		Telephone:	City:

OBSTETRICAL HISTORY

Total Preg: _____ Full Term Births _____ Premature Births _____ No. of Abortions _____
No. of Miscarriages _____ Ectopic Pregnancy _____ Multiple Births (twins) _____ Living Children _____

Month / Day / Year	Weeks Preg.	Weight	Sex	Type of Delivery	Remarks
1)					
2)					
3)					
4)					
5)					
6)					

MENSTRUAL HISTORY

Age at 1st period _____ Date of last period (1st day) _____ Days of cycle _____
Cramps ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe Medication for cramps _____
Duration of bleeding _____ ☐ I have had a hysterectomy Year: Reason:
Last pap: Date: ☐ Normal ☐ Abnormal
Last mammo: Date: ☐ Normal ☐ Abnormal

CONTRACEPTIVE HISTORY

Current method:
Past methods:

PAST MEDICAL HISTORY: *Please check (X) ALL areas that apply to you.*

☐ Anemia / Blood Disease	☐ Gall Bladder Dis	☐ Skin Disease		
☐ Arthritis / Osteoporosis	☐ Headaches / Migraine	☐ Thyroid Disease		
☐ Blood Transfusion	☐ Heart Dis (MVP – RHD)	☐ Tuberculosis		
☐ Bowel Disorders	☐ H. Hernia / Pep Ulcer	☐ Urinary Incont / Infect		
☐ Breast Disease	☐ Hypertension	☐ Varicose V / Phlebitis		
☐ Cancer	☐ Jaundice/ Hepatitis			
☐ Diabetes	☐ Kidney Disease	☐ HPV	☐ Gonor	☐ Chlamydia
☐ Epilepsy / Neur Dis	☐ Respiratory Dis	☐ HIV	☐ Herpes	☐ Syphilis

HOSPITAL ADMISSIONS or SURGERIES (excluding pregnancy)

Year	Description	Year	Description

FAMILY HISTORY: *Have any of your close relatives had any of the following conditions?*

Condition:	Relation to you	Maternal/Paternal	Condition:	Relation to you	Maternal/Paternal
☐ Blood Disease			☐ Hepatitis		
☐ Cancer			☐ Kidney Disease		
☐ Diabetes			☐ Pep Ulcer		
☐ Epilepsy / Neur Dis			☐ Respiratory Dis		
☐ Gall Bladder Dis			☐ Skin Disease		
☐ Heart Dis (MVP – RHD)			☐ Thyroid Disease		
☐ HIV			☐ Tuberculosis		
☐ Hypertension			☐ Phlebitis		

SOCIAL HISTORY

Smoking ☐ Yes ☐ No (#cigs. Per day?) Alcohol ☐ Yes ☐ No ___ Drinks/Week Street Drug:_____

Last Influenza Vaccination Date:

ALLERGIES	Reaction	ALLERGIES	Reaction

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

*PLEASE CHECK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU **CURRENTLY***

CONSTITUTIONAL	RESPIRATORY	SKIN
☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Other	☐ Wheezing ☐ Spitting up blood ☐ Shortness of breath ☐ Cough, chronic ☐ Other	☐ Rash ☐ Ulcers ☐ Other

NECK	GASTROINTESTINAL	BREASTS
☐ Lumps ☐ Other	☐ Frequent diarrhea ☐ Bloody stool ☐ Nausea / vomiting ☐ Constipation ☐ Other	☐ Pain in breast ☐ Discharge ☐ Masses ☐ Implants ☐ Other

THROAT	GENITOURINARY		NEUROLOGIC
☐ Hoarseness ☐ Voice changes ☐ Sore throat ☐ Other	☐ Blood in urine ☐ Pain with urination ☐ Urgency ☐ Frequency of urination ☐ Incomplete emptying	☐ Stress incontinence ☐ Abnormal periods ☐ Painful intercourse ☐ Other	☐ Dizziness ☐ Seizures ☐ Numbness ☐ Trouble walking ☐ Other

CARDIOVASCULAR	MUSCULOSKELETAL	PSYCHIATRIC
☐ Painful breathing ☐ Chest pain ☐ Difficult breathing on exertion ☐ Swelling of legs ☐ Palpitations of heart ☐ Other	☐ Muscle weakness ☐ Pain ☐ Restricted movement ☐ Other	☐ Depression ☐ Frequent crying ☐ Other

PATIENT SECTION:

I hereby certify that the above information is correct.

Name: _____ Signature: _____ Date: _____

PHYSICIAN SECTION:

Reviewed with patient Signature: _____ Jose Medrano, MD