MEDICAL QUESTIONNAIRE

Full Name:	Date:

Date of Birth:		Age:	
Number of Pregnancies:		Live Births:	
Abortions:	Miscarriages:	Preterm deliveries:	
Marital Status:	Nationality:	Occupation:	Height:

QUESTIONS	NO	YES	EXPLANATION
Are you allergic to any medications?			
Are you taking any medications, vitamins or natural remedies? If yes, please list them.			
DO YOU HAVE ANY OF THE FOLLOWING:			
QUESTIONS	**NO**	**YES**	**EXPLANATION**
Diabetes?			
High blood pressure?			
Asthma/Lung disease, tuberculosis?			
Heart problems, defects or murmurs?			
Thyroid disease?			
Epilepsy?			
Cancer?			
Other chronic disease?			
Have you ever had a blood transfusion?			
Did you have diabetes or hypertension when pregnant?			
Have you had your routine vaccinations for the flu, hepatitis, tetanus, etc?			
Have you had surgeries before? (C/section, D&C, etc...)			

QUESTIONS	NO	YES	EXPLANATION
When was your last pap smear?			
Have you had an abnormal mammogram? If yes, indicate the date.			
When was your last mammogram?			
When was you last physical exam?			
Are your periods irregular?			
When was your last menstrual cycle?			
Does your menstrual cycle last more than 7 days?			
Do you use 6 or more pads or tampons per day during your period>			
Are you sexually active?			
Do you use birth control? If yes, which one?			
Do you exercise regularly? If yes, indicate what type of exercise and how often.			
Do you use caffeine? Including soda and energy drinks. If yes, indicate what type and how much?			
Do you smoke? If yes, at what age did you started and how much do you smoke?			
Are you an ex-smoker? If yes, when did you quit and for how long did you smoke for?			
DO you drink or did you use to drink alcoholic beverages? If yes, indicate type of drink and frequency.			
Do you use or did you used drugs before? If yes, indicate type of drug and frequency.			
Does your partner or previous partners ever had a homosexual relationship or used IV drugs?			
Have you had more than 1 sexual partner?			How many this year? How many in lifetime?
Have any of your PARENTS, GRADNPARENTS OR SIBLINGS had any of the following illnesses?			
QUESTIONS	**NO**	**YES**	**EXPLANATION**
Diabetes?			
High blood pressure?			
Cancer?			

QUESTIONS	NO	YES	EXPLANATION
Heart attacks, heart disease?			
Stroke?			
Hepatitis?			
Asthma?			
Epilepsy?			
Thyroid disease or blood disorders?			
Fibrosis or endometriosis?			
Difficulty with anesthesia?			
Sickle cell trait or sickle cell disease??			
Have YOU had any of the following illnesses recently?			
QUESTIONS	**NO**	**YES**	**EXPLANATION**
Unexplained fevers?			
Change in texture of skin or hair?			
Problems with ear, nose or throat?			
Problems with swallowing?			
Trouble breathing?			
Breast lumps, pain or discharge from the breast??			
Dizzy spells or faints?			
headaches?			
Bleeding disorders? Easy bruising?			
Chronic cough?			
Urinary burning or incontinence with cough?			
Black, tarry stools or blood or mucous in the stool?			
Trouble with sexual relations, intimacy or arousal?			
Suicidal thoughts?			
Depression, anxiety, schizophrenic disorders?			
Mental of physical abuse by spouse or family?			
High-risk behavior for sexually transmitted diseases?			

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