McDowell Mountain Gynecology

Patient Name:_____ **Date of Birth:**_____

PATIENT MEDICAL QUESTIONNAIRE

Main reason for office visit today

Specific Problem	Duration

OBSTETRICAL HISTORY

List ALL pregnancies (including miscarriages, abortions, etc.)

	Month/Year	length of Pregnancy	Facility or Hospital	Complications	Birth Wt.	Sex	Name
1.							
2.							
3.							
4.							
5.							

GYNECOLOGICAL HISTORY

Menstrual Periods date of last period _____

Age when you started_____

Pap Smear
Date of last one_____

Where was this done_____

Birth Control
Current method_____

PREVIOUS MEDTHOD USED_____

_____

_____

Which of the following apply to you:

_____unusually painful periods

_____bleeding between periods

_____previously abnormal pap smear

_____Pain with intercourse

_____Feeling that pelvic organs are falling out

_____involuntary loss of urine

_____previous pelvic infection (not vaginal)

_____Previous venereal disease

_____Sexual or marital problems

PAST MEDICAL HISTORY

Existing medical disorders_____

Previous surgery (including breast augmentation, c-section, D & C, tonsils, etc.)

Year	Surgery	Hospital

Previous hospitalizations, other than surgery

Year	Problem	Hospital

Medications

a) Medicines you take: (including birth control) _____

b) Medicines you are allergic to: _____

Personal Habits:

Smoking Y/N Coffee/Caffeine Y/N Alcohol Y/N Recreation Drug (marijuana etc.) Y/N

Have you ever had any of the following problems?

Cardiovascular

Heart trouble	Y/N
Heart murmurs	Y/N
Rheumatic fever	Y/N
Blood Clots (legs or lungs)	Y/N
High blood pressure	Y/N
Anemia	Y/N
Blood transfusions	Y/N
Mitral Valve Prolapse	Y/N

Pulmonary

Chest pains	Y/N
Pneumonia	Y/N
TB or Valley Fever	Y/N
Asthma	Y/N

Gastrointestinal

Gall Bladder problems	Y/N
Yellow Jaundice(hepatitis)	Y/N
Ulcers	Y/N
Bloody stools or vomiting	Y/N
Bowel habit changes	Y/N
Colitis or spastic colon	Y/N

Other

Breast problems, Nipple discharge	Y/N
Cancer	Y/N
Depression	Y/N
Psychiatric care	Y/N
Bone problem	Y/N
Muscle problems	Y/N

Urinary

Kidney infection	Y/N
Bladder infection	Y/N
Blood in urine	Y/N

Neurological

Frequent headaches	Y/N
Fainting spells	Y/N
Convulsions	Y/N

Endocrine

Thyroid problems	Y/N
Diabetes	Y/N
Recent weight change	Y/N

Family History

Any close relatives with:

		Who:			Who:
High blood pressure	Yes	_____	Diabetes	Yes	_____
Breast Cancer	Yes	_____	Other Cancer	Yes	_____
Other conditions/illness	Yes	_____			

The above information is true and correct to the best of my belief.

Patient Signature: _____ **Date:** _____