The Institute for Female Pelvic Medicine & Reconstructive Surgery®

Caring Specialists. Restoring Pelvic Support. Curing Incontinence.

MEDICAL HISTORY QUESTIONNAIRE

***** ALL NEW PATIENTS PLEASE COME TO YOUR VISIT WITH A FULL BLADDER *****

Name	Date of Birth	Age	Drug Allergies:	Reactions:
Please describe the reason for your visit (chief complaint)				

OBSTETRIC HISTORY

Number of Pregnancies:	Vaginal Deliveries:	Cesarean Deliveries:	Largest Baby Weight:
Forceps or Vaccum ☐ Yes ☐ No	Episiotomy ☐ Yes ☐ No	Laceration/Tear ☐ Yes ☐ No	
Degree/Details	Other Complications or Prolonged Labor		

GYNECOLOGIC HISTORY

Gynecologist Name:	Do you experience any of the following? (check ones you have)
Gynecologist Phone Number:	_____ Bleeding between periods
Date of last menstrual period:	_____ Heavy menstrual periods
Date of last PAP smear: Normal?	_____ Pain with periods
Date of last mammogram: Normal?	_____ Bleeding after intercourse
Have you ever had a sexually transmitted disease? If yes, when?	_____ Pain with intercourse
Are you sexually active at the present time?	_____ "Falling" of pelvic organs or prolapse
Are you using contraception? If yes, what type?	Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:

MEDICAL CONDITIONS AND MEDICATIONS

Please list ALL your medical conditions, the medication(s) you are taking for them (if any), how long you have been on the medication

Medical Condition	**Name of Medication**	**Dosage How often you take it**	**How long have you been on the medication**
Example - Hypertension	*Tenormin*	*50mg 1 daily*	*2 years*

Reviewed with Patient _____

Drs Initials & Date

Name	DOB	Date

PAST SURGICAL AND HOSPITAL HISTORY: ☐ **None** ☐ **Yes, if yes**

Please describe your past experience with, **operations**, serious injuries, all and any hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk? Please circle **Y** or **N** for each condition and **F** - father, **M** – Mother, **S** - Sibling (no blanks please ☺)

Condition	Yes/No	Who
Adopted	Y / N	N/A
Asthma	Y / N	F / M / S
Bleeding problems	Y / N	F / M / S
Breast disease	Y / N	F / M / S
Breast CA	Y / N	F / M / S
Cancer (indicate type)	Y / N	F / M / S
Diabetes	Y / N	F / M / S
Heart disease	Y / N	F / M / S
High blood pressure	Y / N	F / M / S
Kidney disease	Y / N	F / M / S
Stroke	Y / N	F / M / S
Thyroid disease	Y / N	F / M / S
Other	Y / N	F / M / S

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Drug / Alcohol Use Yes No Drinks/week:

Current Smoker ☐ Yes ☐ No # of cigarettes/day:

Former Smoker ☐ Yes ☐ No

Never Smoked ☐

Highest level of Education

Employment (please include job title)

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Ethnicity: ☐ Latino / Hispanic ☐ Other ☐ Refused

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?

Please Circle **Y** or **N** or any condition(s) you have had or that you have currently. (no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight change	Y	N	Fatigue	Y	N			
Eyes:	Vision changes	Y	N	Cataracts	Y	N	Glaucoma	Y	N
Ears/Nose/Mouth/Throat:	Ulcers	Y	N	URI (upper respiratory infection)	Y	N			
Cardiovascular:	Heart conditions	Y	N	Orthopnea (difficulty breathing when lying down)	Y	N	DOE (difficulty breathing on exertion)	Y	N
Respiratory:	SOB (short of breath)	Y	N	Wheezing	Y	N			
Gastrointestinal:	Nausea/Vomiting	Y	N	Diarrhea	Y	N	Bloody Stool	Y	N
Musculoskeletal:	Weakness	Y	N						
Integumentary/Skin:	Rash	Y	N						
Neurological:	Seizure	Y	N	Syncope (fainting)	Y	N	Neuropathy	Y	N
Psychiatric:	Depression	Y	N	Anxiety	Y	N			
Endocrine:	Hot flashes	Y	N	Diabetes	Y	N	Thyroid	Y	N
Hematologic/Lymphatic:	Easy bruising	Y	N	Bleeding	Y	N	Adenopathy (Swollen Glands)	Y	N
Allergic/Immunologic:	Seasonal	Y	N	Animal Dander / Foods	Y	N			

Other:

_____ Patient Signature

_____ Date

Reviewed with Patient _____

Drs Initials & Date