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 |
| Date of last colonoscopy: Normal? | _____ Pain with intercourse |
| Have you ever had a sexually transmitted disease? If yes, when? | _____ "Falling" of pelvic organs or prolapse |
| Are you sexually active at the present time? | Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral: |
| Are you using contraception? If yes, what type? | |

## 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* |
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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