The Female Pelvic Health Center
Medical Questionnaire

Name	Date of Birth	Age	Drug Allergies: ☐ yes ☐ no If yes, medication and REACTION:
Please describe the reason for your visit (chief complaint):			

Number of Pregnancies	Number of Vaginal Deliveries:	Number of Cesarean Deliveries
Forceps or vacuum? ☐ Y ☐ N	Episiotomy? ☐ Y ☐ N	Laceration/tear? ☐ Y ☐ N Degree? 1 2 3 4 unsure
Largest baby (wt)	Other complications? Prolonged labor?	Hysterectomy ☐ Yes ☐ No abdominal ☐ vaginal ☐ laparoscopic☐ Have ovaries been removed? Rt ☐ Lt ☐

GYNECOLOGIC HISTORY

Date of last menstrual period:	Do you experience any of the following? (check ones you have) _____ Bleeding between periods _____ Heavy menstrual periods _____ Pain with periods _____ Bleeding after intercourse _____ Pain with intercourse _____ "Falling" of pelvic organs or prolapse
Date of last PAP smear: Normal?	
Date of last mammogram: Normal?	
Date of last colonoscopy: Normal?	
Have you ever had a sexually transmitted disease: ☐Yes ☐ No If yes, what?	Are you presently taking hormone replacement therapy? ☐yes ☐ No
Are you sexually active at the present time: ☐ Yes ☐ No	If yes, what medication and is it vaginal or oral:
Are you using contraception? ☐ Yes ☐ No If yes, what type?	

MEDICAL CONDITIONS AND MEDICATIONS *Please list ALL your medical conditions, and medications*

MEDICAL CONDITIONS :	**MEDICATIONS & DOSAGE** (please include all vitamins and supplements)
Example: High Blood Pressure	*Example: Lopressor 10 mg 1x day*

Please answer questions below:

Do you have glaucoma? ☐ **YES** ☐ **NO** If yes, is it open/wide angle (or) narrow angle? _____________
Are you Diabetic? ☐ **YES** ☐ **NO**
Do you take blood thinners (Coumadin, Plavix, Aggrenox, Pradaxa, etc) ☐ **YES** ☐ **NO**

Name: Date of Birth:

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

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

FAMILY HISTORY

Are there medical events **in your family's history (not your history)**, including diseases that may be hereditary or place you at risk? Please mark **Y** or **N** for each condition (no blanks please ☺)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	High blood pressure	☐	☐	Heart disease	☐	☐	Thyroid disease
☐	☐	Stroke	☐	☐	Diabetes	☐	☐	Asthma
☐	☐	Kidney disease	☐	☐	Liver disease	☐	☐	Breast disease
☐	☐	Breast Cancer	☐	☐	Ovarian Cancer	☐	☐	Bleeding Problems
☐	☐	Other Cancer (indicate type)						

SOCIAL HISTORY

Marital Status:

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

Current Alcohol Use: ☐ YES ☐ NO
Current Drug Use: ☐ YES ☐ NO
History of drug/alcohol addiction:
☐ YES ☐ NO
# of Drinks/week: ______________

Never Smoked: ☐
Former Smoker: ☐ Yes ☐ No
Current Smoker: ☐ Yes ☐ No
# of Cigarettes/day:__________

Highest Level of Education:

Employment (please include job title):

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

Ethnicity: ☐ Latino/Hispanic ☐ Other

REVIEW OF SYSTEMS

Please mark box for **Yes** or **No** for any condition(s) you have had or that you have currently.
(no blanks please ☺)

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight loss	☐	☐	Chills	☐	☐			
Eyes:	Blurred vision	☐	☐	Double vision	☐	☐	Eye Pain	☐	☐
Ears/Nose/Mouth/Throat:	Hearing loss	☐	☐	Sore throat	☐	☐			
Cardiovascular:	Chest pain	☐	☐	Palpitations	☐	☐	Heart Murmur	☐	☐
Respiratory:	Chronic cough	☐	☐	Wheezing	☐	☐			
Gastrointestinal:	Nausea/Vomiting	☐	☐	Diarrhea	☐	☐	Bloody Stools	☐	☐
Musculoskeletal:	Arthritis	☐	☐						
Integumentary/Skin:	Rash	☐	☐						
Neurologic:	Seizure	☐	☐	Memory loss	☐	☐	Headache	☐	☐
	Neuropathy	☐	☐						
Psychiatric:	Depression	☐	☐	Anxiety	☐	☐			
Endocrine:	Hot flashes	☐	☐	Fatigue	☐	☐			
Hematologic/Lymphatic:	Easy bruising	☐	☐	Easy Bleeding	☐	☐			
Allergic/Immunologic:	Seasonal	☐	☐	Animal Dander / Foods	☐	☐	Asthma	☐	☐

Other: