Blue Ridge Women's Center, PA

Medical Questionnaire

Date of Visit: ____________ Age:_____ If OB Visit, Father of Baby:_______________________________

Name: ____________________________________ Reason For Visit: ____________________

Address: __________________________________ City: __________________ State: _____ Zip: ______

Home Phone: __________________ Work Phone: __________________ Cell Phone: __________________

Date of Birth: __________________ Age: ___________ Occupation: __________________________

How did you hear about our office? ☐ Physician ☐ Newspaper ☐ Yellow Page ☐ Friend ☐ Other

Name of person who referred you to our office? ____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Pharmacy: __________________________

Primary Care Physician & Phone Number: ____

***** ALLERGIES:** __________________________ Type of Reaction:_____________________________***

Menstrual History First Day of Last Menstrual Period: _______________ Age at 1st Period: __________

\# Days of Flow: ____________ Amount (heavy, normal, light): ____________ Length Between Periods: __________

Have you ever been pregnant? ☐ Yes ☐ No How many times: _________

\# Full Term: __________ # PreTerm: ___________ # vaginal deliveries ____________

\# Miscarriages: _________ # Living Children: ____________ # c-section deliveries ___________

\# Abortions: __________ Dates of Child(ren) Births: ____

Any pregnancy complications: ____

Do you use birth control? If so, what type:

☐ Pills ☐ Diaphragm ☐ Depo Provera ☐ Norplant ☐ NuvaRing ☐ Abstinence

☐ IUD ☐ Vasectomy ☐ Tubal Ligation ☐ Condoms ☐ Rhythm Method

Do you use hormone replacement? ☐ Yes ☐ No Rx: ____

Medical History: ***Check if you have had any of the following:***

☐ Cancer Type:__________________	☐ High Blood Pressure	☐ Anemia	☐ Depression
☐ Abnormal Pap Smear Date:__________	☐ Heart Disease	☐ Thyroid Problems	☐ Alcoholism
☐ Pelvic Infection	☐ Mitral Valve Prolapse	☐ Diabetes	☐ Digestive Problems
☐ Sexually Transmitted Disease	☐ With Antibiotic Therapy	☐ Tuberculosis	☐ Drug Addiction
☐ Phlebitis/Blood Clots in Legs	☐ High Cholesterol	☐ Hepatitis	☐ Headaches

Do you currently take any prescription medications? If so, please list Names of Medicines, Dosage and Times of Day:

____

Surgical History: ***Have you had any female surgery? When:*** _______________

☐ Breast ☐ Hysterectomy ☐ D & C ☐ Ectopic Pregnancy ☐ Fibroid Tumors

☐ Ovary ☐ Laparoscopy ☐ Cesarean Section ☐ Laser/LEEP/Cryo ☐ Other

Reason for Surgery/Findings: ____

Please list any other surgery: (i.e., appendectomy, heart surgery, etc.) ______________________________

____

Social History / Habits:

Do you perform breast exams? ☐ Yes ☐ No How often? ______________________

Have you had a mammogram of your breast? ☐ Yes ☐ No If so, when: __________Where:__________

Have you ever had an abnormal mammogram? ☐ Yes ☐ No If so, when: __________Where:__________

Do you have a Pap Smear yearly? ☐ Yes ☐ No Date of Last Pap: ______________________

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Please complete back side of page

Social History / Habits: (Continued)

Have you ever smoked?	☐ Yes ☐ No	How Much? ______	☐ Quit Years: ______
Do you drink alcohol?	☐ Yes ☐ No	How Much? ______	How Often? ______
Do you use street drugs?	☐ Yes ☐ No	What Kind? ______	How Often? ______
Do you exercise?	☐ Yes ☐ No	How Often? ______	
Are you at risk for HIV infection?	☐ Yes ☐ No	Age at First Intercourse? ______	
Are you or have you ever been threatened or physically, sexually, or mentally abused?	☐ Yes ☐ No	Sexual Partners: ☐ Less than (5) ☐ More than (5)	

Family History: Check if Applies (Siblings, Parents, Grandparents)

	(Family Member)		(Family Member)
☐ Breast Cancer	______	☐ Tuberculosis	______
☐ Ovarian Cancer	______	☐ Diabetes	______
☐ Other Cancer	______	☐ Bleeding Disorder	______
☐ Birth Defects	______	☐ Alcoholism	______
☐ High Blood Pressure	______	☐ Mental Retardation	______
☐ Heart Attack	______	☐ Osteoporosis/Osteopenia	______
☐ High Cholesterol	______	☐ Other	______

REVIEW OF SYSTEMS – ***Please check if you are having problems with any of the following:***

Genital/Urinary

- ☐ Vaginal Warts
- ☐ Vaginal Dryness
- ☐ Absence of Period
- ☐ Heavy Vaginal Bleeding
- ☐ Irregular Vaginal Bleeding
- ☐ Painful Menstrual Periods
- ☐ Painful Intercourse
- ☐ Urinary Urgency
- ☐ Pain/Burning w/ Urination
- ☐ Urination at Night
- ☐ Bladder Control/Leakage
- ☐ Urinary Tract Infections

Constitutional

- ☐ Fatigue
- ☐ Hair Loss
- ☐ Weight Gain or Loss
- ☐ Hot Flashes

Skin / Breast

- ☐ Nipple Discharge
- ☐ Sore That Does Not Heal
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Changes in Mole
- ☐ Rashes/Persistent Itching

Neurological

- ☐ Frequent Headaches
- ☐ Poor Coordination
- ☐ Muscle Weakness
- ☐ Trouble Sleeping

Psychiatric

- ☐ Depression
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Memory Changes
- ☐ Counseling or Treatment

HENT

- ☐ Visual Problems
- ☐ Hearing Loss
- ☐ Allergies/Hayfever
- ☐ Hoarseness
- ☐ Frequent Sore Throat
- ☐ Sinus Problems
- ☐ Mouth Ulcers
- ☐ Fainting/Dizziness

Digestive

- ☐ Heart Burn
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Black Stools
- ☐ Diarrhea
- ☐ Yellow Jaundice

Cardiac

- ☐ Chest Pain
- ☐ Irregular Heart Beat

Respiratory

- ☐ Shortness of Breath
- ☐ Coughed Blood
- ☐ Wheezing