The Women's Health Center
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Medical History Questionnaire

Name: _____

Age: _____ Date of Birth: _____ Date: _____

Past Medical History

Please check box if you have a history of...

- ☐ Anemia
- ☐ Asthma
- ☐ Bladder trouble
- ☐ Blood Clot in leg (s)
- ☐ Bowel trouble (constipation, diarrhea)
- ☐ Breast mass
- ☐ Diabetes (type 2)
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Seizures
- ☐ Thyroid Disorder

☐ Other medical issues :

_____

_____

Prior blood transfusion? Y N
(please circle)

Past Surgical History

Have you had any of the following surgeries?

- ☐ Appendix removal
- ☐ Breast biopsy
- ☐ Cesarean section (s)
- ☐ D & C
- ☐ Ectopic pregnancy
- ☐ Endometriosis surgery
- ☐ Gallbladder removal
- ☐ Hysterectomy:
  - ☐ LSH (supracervical hyst.)
  - ☐ LAVH (laparoscopic assisted)
  - ☐ TAH (abdominal hyst.)
  - ☐ VH (vaginal hysterectomy)
  - ☐ TLH (total laparoscopic hyst.)
- ☐ Mastectomy
  - ☐ Bilateral
  - ☐ Left breast removed
  - ☐ Right breast removed
- ☐ Ovarian cyst drainage
- ☐ Ovary removal
  - ☐ Both ovaries removed
  - ☐ Right ovary removed
  - ☐ Left ovary removed
- ☐ Tubal Ligation
- ☐ Other surgeries: 1. _____ 2. _____

Medication List

Please list all current medications & supplements. Include mg dose & # times / day taken.

1. _____ by _____ Name of doctor who prescribed this medication
2. _____ by _____ Name of doctor who prescribed this medication
3. _____ by _____ Name of doctor who prescribed this medication
4. _____ by _____ Name of doctor who prescribed this medication
5. _____ by _____ Name of doctor who prescribed this medication

The Pharmacy that I typically use is:

Allergies:

☐ I have no known drug allergies

☐ I am allergic to the following: _____

I was referred to The Women's Health Center by: _____

Family Medical History

Please check box if a family member has had…

Condition	Which family member?
☐ Breast Cancer	_____
☐ Colon Cancer	_____
☐ Diabetes	_____
☐ Endometriosis	_____
☐ High Blood Pressure	_____
☐ Ovarian Cancer	_____
☐ Thyroid Disorder	_____
☐ Other:	_____

Family Genetic History

☐ *I am not aware of any genetic disorders or syndromes that run in my family.*

or

Is there a family history of any of the following?

- ☐ Cystic Fibrosis
- ☐ Down Syndrome
- ☐ Fragile X Syndrome
- ☐ Heart defects
- ☐ Hemophilia
- ☐ Kidney malformation
- ☐ Mental retardation
- ☐ Sickle-Cell Trait
- ☐ Spina Bifida
- ☐ Thalassemia
- ☐ Other:

Hereditary Cancer Risk Assessment: *Is there a pattern of cancers in your family?*

Please check box if any of following run in your family:

- ☐ Ashkenazi Jewish ancestry
- ☐ Breast cancer in multiple family members
- ☐ Breast cancer diagnosed prior to age 50
- ☐ Colorectal cancer diagnosed prior to age 50
- ☐ Male breast cancer
- ☐ Melanoma (skin cancer) in multiple family members
- ☐ Ovarian cancer – diagnosed at any age
- ☐ Pancreatic cancer along with breast or ovarian cancer
- ☐ Stomach cancer
- ☐ Uterine cancer diagnosed prior to age 50

Reproductive & Menstrual History

I [have / have not] (please circle) had a mammogram before. Date? (recent MMG)

Age when my period started _____ yrs. My cycle typically comes every (number) days.

My cycles typically last for (number) days. I would describe my flow as: (please circle) Light / Medium / Heavy

I typically use (number) tampons and / or (number) pads each month.

My last period started on: (date) History of STDs?: YES NO (please circle)

Method of birth control: _____ I [do / do not] (please circle) pass clots during my cycle.

Breakthrough bleeding?: YES NO (please circle) Currently taking hormone replacement?: YES NO (please circle)

My most recent pap smear was (date) History of abnormal pap smears?: YES NO (please circle)

Pregnancy Summary

This refers to how many weeks along you were when you delivered. Due date = 40 weeks

Miscarriages: _____

Date	GA	Hrs in Labor	Birth Wt.	Gender	Vaginal or C section?	Preterm labor?	Hospital

Smoke cigarettes? ❑ Yes ❑ No

 # packs per day: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation:

Spouse Name:

Thank you for completing this questionnaire form.
We look forward to taking good care of you!

The Women's Health Center Staff

Office staff will complete this box:

Total Preg	Full Term	Premature	Ab Induced	Ab Spontaneous	Ectopics	Multiple	Living
#	#	#	#	#	#	#	#