FEMALE CONTINENCE & PELVIC SURGERY CENTER

MEDICAL HISTORY QUESTIONNAIRE

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:

Gynecologist Phone Number:

Date of last menstrual period:

Date of last PAP smear: Normal?

Date of last mammogram: Normal?

Have you ever had a sexually transmitted disease? If yes, when?

Are you sexually active at the present time?

Are you using contraception? If yes, what type?

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

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 (no blanks please ☺)

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

SOCIAL HISTORY

Marital Status Single Married Widowed Separated Divorced	Drug/Alcohol Use: Yes No Drinks/week	Current Smoke r: ☐ Yes Former Smoker : ☐ Yes # of Cigarettes/day 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:	Chest pain	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

Please list any allergies you have to any medications and the reaction it caused.

Medication(s) you are Allergic to	Reaction