Jefferson Center for Women's Medical Specialties

Medical History Questionnaire

Name

Date

Birthdate

Marital Status
☐ S ☐ M ☐ D ☐ W ☐ Sep

Social Security

I am here today for

Family/Primary Care Physician/Internist

Name

Address

Phone Number

Do you see any specialists? ☐ Yes ☐ No

Name

Address

Phone Number

Name

Address

Phone Number

Who referred you to our practice? ☐ Primary Care Physician ☐ Other

Pregnancy History

Age at first pregnancy

Year of Pregnancy	Miscarriage	Abortion	Ectopic Pregnancy	Vaginal Delivery	Cesarean Delivery	Girl	Boy	Weight	Wks Preg At Deliv.	Problems

Name	Date

Family History

List anyone in your family (parents, grandparents, siblings or children) who had/have

Yes	No		Yes	No	
☐	☐	Breast disease/cancer	☐	☐	High Blood Pressure
☐	☐	Osteoporosis	☐	☐	Strokes, Blood Clots
☐	☐	Diabetes	☐	☐	High Blood Fats (Cholesterol, lipids, etc.)
☐	☐	Heart Attack before age 50	☐	☐	Colon Cancer
☐	☐	Other Heart Disease	☐	☐	Prostate Cancer
☐	☐	Cervical Cancer	☐	☐	Other Cancers
☐	☐	Endometrial Cancer	☐	☐	Lung Disease
☐	☐	Ovarian Cancer	☐	☐	Kidney Disease
☐	☐	Anemias	☐	☐	Birth defects/Genetic Problems/Traits
☐	☐	Alzheimer’s Disease			

Father	Mother
☐ living ☐ deceased	☐ living ☐ deceased
Cause of death	Cause of death

☐ I am adopted – birth family history unknown

Personal History

Have you ever had

Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Vaginal Infections (Yeast, bacterial)
☐	☐	Cancer	☐	☐	Sexually Transmitted Diseases (syphilis, gonorrhea, genital herpes, chlamydia, trichomons, genital warts, etc.)
☐	☐	Visual Problems not corrected by glasses such as blurred or double vision	☐	☐	Infections of uterus, tubes, ovaries, PID
☐	☐	Headaches (frequent/severe) migraines/dizzy	☐	☐	Other problem with uterus/tubes (i.e., fibroids, cysts, etc.)
☐	☐	Epilepsy, convulsions, fainting	☐	☐	Abnormal pap smear
☐	☐	Thyroid Disease	☐	☐	Pain or bleeding with sex
☐	☐	Hormonal problems, abnormal hair growth	☐	☐	Psychiatric/Emotional Problems
☐	☐	Acne	☐	☐	Mental Depression
☐	☐	Lung problems (tuberculosis, asthma, bronchitis	☐	☐	German measles/rubella
☐	☐	Liver Disease (hepatitis, mono, jaundice	☐	☐	Chicken Pox/varicella
☐	☐	Heart Disease/Murmurs/Rheumatic fever	☐	☐	Measles/rubeola
☐	☐	Strokes/Blood Clots (legs/lungs)	☐	☐	Did your mother take DES while pregnant with you?
☐	☐	Varicose Veins	☐	☐	Do you smoke? How much?
☐	☐	Blood Problems	☐	☐	Alcohol use? per week
☐	☐	High Blood Fats (cholesterol, lipids, etc.)	☐	☐	Drug use? Type and Frequency?
☐	☐	Fluid retention, especially feet or ankles	☐	☐	IV drugs?
☐	☐	Kidney Disease (infections, cysts, stones)	☐	☐	Blood Transfusions?
☐	☐	Loss of Urine	☐	☐	Exercise?
☐	☐	Pain or Bleeding with Urination	☐	☐	Do you use seat belts in the car?
☐	☐	Gall Bladder Disease/Stones	☐	☐	Have you had Choleaterol Screening? Date of last screen?
☐	☐	Stomach or Bowel Pain or Problems	☐	☐	Have you ever had a relationship in which there was physical, sexual or psychological abuse?
☐	☐	Breast Problems (lumps, tumors, cysts, nipple discharge, cancer)	☐	☐	Do you regularly do self breast exams?
☐	☐	Have you had a mammogram? Date of last mammogram	☐	☐	Surgery: Type and Year

Thomas Jefferson University | Jefferson University Physicians

Jefferson Center for Women's Medical Specialties

Medical History Questionnaire

Name	Date

☐ Yes ☐ No Hospitalizations? Why and When

How would you rate your health now? ☐ Good ☐ Fair ☐ Poor

Allergies

Do you have any medication allergies? ☐ Yes ☐ No

Medication	Reaction

List any allergies to foods, metals or other substances

Medications

Are you currently taking any medication? ☐ Yes ☐ No If yes, list:

Medication	Dosage	Reason for Taking

Menstrual History

Age of First menses	First day of last menstrual period	Periods come every __________ days	Number of Days of flow

Are your periods: ☐ light ☐ moderate ☐ heavy ☐ clots

☐ Yes ☐ No Was this period normal?

☐ Yes ☐ No Do you think you may be pregnant now?

☐ Yes ☐ No Do you ever miss periods?

☐ Yes ☐ No Do you ever bleed between periods?

☐ Yes ☐ No Do you take medication for pain? Name of medication

☐ Yes ☐ No If you are menopausal, have you had bleeding?

Name	Date

Sexual and Contraceptive History

Age of first intercourse

Number of partners since first intercourse

Number of partners last year?

Partners ☐ Male ☐ Female ☐ Both

Are you using birth control now? ☐ Yes ☐ No

Do you plan children in the future? ☐ Yes ☐ No ☐ Undecided

If you and your partner want birth control, what method do you want?

Are you satisfied with your current contraceptive method?

☐ I am interested in HIV Testing/Information

☐ I would like to be screened for STD's (gonorrhea, chlamydia, syphilis, hepatitis)

☐ Do you have any questions about sex you'd like to discuss?

Please check all methods used by you or partner

	Type	Date Used
☐ Pills		
☐ IUD/Coil		
☐ Diaphragm		
☐ Tubal ligation		
☐ Vasectomy		
☐ Other		

Contraceptive Method Problems

Pill	IUD	Diaphragm
☐ Yes ☐ No Headaches	☐ Yes ☐ No Abdominal Pain	☐ Yes ☐ No Unusual vaginal bleeding
☐ Yes ☐ No Blurred, double vision	☐ Yes ☐ No Unusual vaginal bleeding	☐ Yes ☐ No Discomfort
☐ Yes ☐ No Pain, swelling of legs	☐ Yes ☐ No Fever or chills	☐ Yes ☐ No Urinary Tract infections
☐ Yes ☐ No Chest pain, shortness of breath	☐ Yes ☐ No Abdominal Pain	
☐ Yes ☐ No Abdominal Pain		
☐ Yes ☐ No Jaundice		
☐ Yes ☐ No Severe depression		

Exam /Pap/Problems

☐ Yes ☐ No Do you have symptoms of infection (itching, burning, discharge)?

Date of last pap

Result

PSYCHOSOCIAL SCREENING
϶ Yes ϶ No Do you have any problems (job, transportation, etc.) that prevent you from keeping health care appointments?
϶ Yes ϶ No Do you feel unsafe where you live?
϶ Yes ϶ No In the past 2 months, have you used any form of tobacco?
϶ Yes ϶ No In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
϶ Yes ϶ No In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
϶ Yes ϶ No Has anyone forced you to perform any sexual act that you did not want to do?
On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High
How many times have you moved in the past 12 months? ______________
If you could change the timing of this pregnancy, would you want it ϶ Earlier ϶ Later ϶ Not at all ϶ No change
϶ Yes ϶ No Do you or any family member have a history of problems with anesthesia? If yes, please describe:____ ____ ____
϶ Yes ϶ No Do you have any religious objections to any form of medical treatment, for example, refusal of a blood transfusion? If yes, please describe: ____ ____ ____