CONFIDENTIAL PATIENT MEDICAL HISTORY QUESTIONNAIRE

PRINT NAME ____ **DOB** _____________________

REASON FOR VISIT____

ARE YOU DEPRESSED? YES____ NO_____

-Little interest of pleasure in doing things?

___Not at all ___Several days ___ More than half the days ____ Nearly every day ___ Declined to specify

-Feeling down, depress, or hopeless?

___Not at all ___Several days ___ More than half the days ____ Nearly every day ___ Declined to specify

Current Medications: (Name, dose and reason for taking)

____

____

____

____

PAST MEDICAL AND FAMILY HISTORY

Please check ✔if you (self) or any blood relative (family) had any of the following conditions.

Medical History:	Self	Family		Self	Family
Headache/Migraine	___	___	Liver Disease	___	___
Seizure Disorder	___	___	Colon Disease	___	___
Thyroid Disease	___	___	Kidney Disease	___	___
Wt. Loss/Gain	___	___	Urinary Infections	___	___
Heart Disease	___	___	Urinary Incontinence	___	___
High Blood Pressure	___	___	Anemia/Blood Disorder	___	___
Lung Disease	___	___	Blood Transfusions	___	___
High Cholesterol	___	___	Varicose veins/Phlebitis	___	___
Diabetes	___	___	Osteoporosis	___	___
Breast Cancer	___	___	Anxiety/Depression	___	___
Acid Reflux	___	___	Cancer (Specify Type)		
Peptic Ulcer (Stomach)	___	___	Colon	___	___
HIV/AIDS	___	___	Ovarian	___	___
Hep B	___	___	Uterine	___	___
Hep C	___	___	Endometrial	___	___

If yes, please use the lines below to describe type of illness, date of diagnosis and treatment.

____

____

____

Have you ever been treated for MRSA (Methicillin-Resistant Staphylococcus Aureus)?
If yes, when contracted, place of exposure, treated by whom? (Please explain)

____

____

____

ALLERGIES (please specify)____

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PRINT NAME ____ **DOB** ____________________

OBSTETRIC HISTORY
Please fill in the number of:

Pregnancies _____
Premature births _____
Miscarriages _____
Abortions _____
Living children _____

For each pregnancy please fill in:

Date of Birth	Weeks Pregnant at Delivery	Birth weight	Sex	Type of Delivery

PAST SURGERIES
Please list the date and name of the procedure and reason for any surgeries not listed above.

____
____
____

PAST HOSPITALIZATIONS
Please list date and reason for any overnight stay in the hospital, excluding the birth of a child.

____
____
____
____
____

Gynecologic History:
Please list below the date, name and reason for any procedure done on your cervix, uterus or ovaries including abnormal Pap Smears.

____
____
____

Menstrual History:

Age at 1st period _____
Date of last period _____
How often do you have a period? _____
How long does your period last? _____
How many periods in the last year? _____

	Yes	No
Pain with periods?	___	___
Medication for menstrual pain?	___	___
Bleeding/spotting between periods?	___	___
Describe ______________________________		
Bleeding/spotting after intercourse?	___	___
Describe ______________________________		

CONFIDENTIAL PATIENT MEDICAL HISTORY QUESTIONNAIRE

PRINT NAME ____ **DOB** ____________________

Date of menopause or hysterectomy ____

Symptoms with menopause ____

Treatment for menopausal symptoms ____

Date of last mammogram _____________ Result ______________________

Do you have a personal history of any breast problems? Yes ___No ___

If yes, please describe ____

____

Date of last pap smear _____________ Result ______________________

Please describe your current method of contraception. If a pill, please include name.

____

	YES	**NO**
Do you have a history of vaginal infections or STDs?	___	___

If yes, please explain ____

____

	YES	**NO**
Have you ever been tested for HIV?	____	____

SEXUAL HISTORY

Have you ever had vaginal intercourse (sex)?	___	___
Have you recently had sex with a new partner?	___	___
Have you ever had intercourse against your will?	___	___
Have you previously or currently been abused by your partner?	___	___

SOCIAL HISTORY	**YES**	**NO**		
Do you SMOKE?	___	___	If yes, how much daily?________	How many years? Quit? __
Do you drink ALCOHOL?	___	___	If yes, how much? ____________	How often? _____
Do you use street DRUGS?	___	___	If yes, what type? _____________	How often? _____
Do you use CAFFEINE?	___	___	If yes, what type? _____________	How much daily? __________
Do you exercise?	___	___	If yes, how often? _____________	How long at a time? ________
Do you take Folic Acid	___	___	If yes, how often? _____________	How much at a time? _______

Occupation ______________________________

Note: Confidential documents are absolutely held to the highest degree of ethical and legal status. This medical facility rigidly complies in strict accordance with the laws and regulations of the State of Illinois and/or federal confidentiality legislation designed to protect the rights of the patient.

Signature ___________________________________**Date** ___________________________________

Rev. 12/26/19

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