Main Line HealthCare
Physician Network

Gynecology at Lankenau/Lafayette Hill/Center City/Bala Cynwyd
Medical History Questionnaire

Date:_____

Name:_____ **Birthdate:**_____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated ___Partnered

I am here today:
- □ For a routine annual/gyn exam
- □ To talk about menopause issues (please list any issues below)
- □ To talk about sexual health issues (please list any issues below)
- □ To have a problem evaluated (please describe your problem)

_____

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_____

Family/Primary Care Physician/Internist:

Name:_____

Address:_____

_____

Phone Number:_____ Fax #:_____

Do you see any specialists? □ **Yes** □**No**

Name:_____ Name_____

Address:_____ Address:_____

_____ _____

Phone #:_____ Phone #:_____

Who referred you to our practice?_____

PREGNANCY HISTORY: **AGE AT FIRST PREGNANCY:**_____ **NUMBER OF LIVING CHILDREN:**_____

Year of Pregnancy	Miscarriage	Abortion	Ectopic Pregnancy	Vaginal Delivery	Cesarean Delivery	Girl	Boy	Weight	# weeks preg. At del.	Problems

Name:_____ **Birthdate:** _____ **Date:**_____ **PAGE 2**

FAMILY HISTORY: *List anyone in your family (parents, grandparents, sisters, brothers, children, aunts, uncles) who have or had:*								
Has anyone in your family had:	***Who?***	**Mom's side**	**Dad's side**		***Has anyone in your family had:***	***Who?***	**Mom's side**	**Dad's side**
Breast disease/cancer					Blood Clots – Legs? Lungs?			
Osteoporosis					High cholesterol, lipids, etc.			
Diabetes					Colon cancer			
Heart attack before age 50					Prostate cancer			
Cervical cancer					Other cancers			
Uterine cancer					Birth defects/genetic problems/traits			
Ovarian cancer								
Alzheimer's disease					*Is there any other family history we should be aware of?*			
High blood pressure								
Strokes					***☐ I am adopted – birth family history unknown***			
Is your: Father: □ Living □ Deceased - cause of death:								
Mother: □ Living □ Deceased – cause of death:								

PERSONAL HISTORY - Have <u>YOU</u> ever had:						
	YES	NO			YES	NO
High blood pressure				Have you had cholesterol screening? If yes, when was your last screening		
Mitral valve prolapse						
Diabetes				Have you had a mammogram? If so, when was your last one?		
Cancer						
Vaginal infections (yeast, bacterial)				Have you had a colonoscopy? Date:		
Pain or bleeding with sex				Have you had a bone density (DEXA)? Date:		
Sexually transmitted diseases (syphilis, gonorrhea, genital herpes, chlamydia, trichomonas, genital warts, etc.)				Do you smoke or have you ever smoked? If yes, _____Cigarettes _____Cigars #of packs per day _____packs/cigarettes If yes, at what age did you start smoking? _____ If you are a former smoker, at what age did you stop smoking? _____		
Infections of uterus, tubes, ovaries, PID						
Other problems with uterus/tubes (fibroids)						
Abnormal pap smear						
Did your mother take diethylstilbestrol (DES) while pregnant with you?				Do you drink alcohol/beer/wine? If yes, how often do you drink? ___<1 drink per day ___1-2 drinks/day ___2 or more drinks/day ___1-2 drinks/month		
Thyroid disease						
Hormonal problems, abnormal hair growth						
Acne				Do you exercise? If yes, how often? _____ times per week If yes, what type of exercise do you do?		
Migraines						
Epilepsy, convulsions, fainting						
Strokes				Do you use seatbelts in the car?		
Heart disease/murmurs/rheumatic fever				Do you have firearms in your home?		
Liver disease (Hepatitis B or C, mono)				Have you ever had or are you currently in a relationship in which there was physical, sexual or psychological abuse?		
Lung problems (tuberculosis, asthma, bronchitis)						
Blood problems (anemia, sickle cell)						
High blood fats (cholesterol, lipids, etc)				Do you use recreational drugs? If yes, what type? _____ How often do you use them? _____		
Loss of urine						
Pain or bleeding with urination						
Gallbladder disease/stones				***HAVE YOU EVER HAD THESE VACCINES:***		
Stomach or bowel pain or problems				Flu (influenza)		
Breast problems (lumps, tumors, cysts, nipple discharge, cancer)				Herpes zoster (shingles) (age ≥ 60 years)		
				Pneumonia (age ≥ 60 years)		
Psychiatric/emotional problems?				Hepatitis A		
Mental depression?				Hepatitis B		
				Gardasil (ages 9-26)		

SURGERIES, HOSPITALIZATIONS OR OTHER MEDICAL CONDITIONS

Type of Surgery/Hospitalization/Medical Condition	Dates occurred	Why was it done (surgery)?

PLEASE LIST ANY ALLERGIES TO MEDICATIONS

MEDICATION NAME	ALLERGIC REACTION YOU EXPERIENCED

OTHER ALLERGIES (foods, metals or other substances):

Substance Name	ALLERGIC REACTION YOU EXPERIENCED

MEDICATIONS YOU CURRENTLY TAKE (PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, HERBAL SUPPLEMENTS)

Medication Name	Dosage	Reason you take it

(If your medication list exceeds this area, feel free to attach your list on a separate paper)

MENSTRUAL HISTORY

First day of your last menstrual period:	**Age of your first period:**
If you are menopausal, have you had bleeding? _____Yes _____No	
If you are menopausal, have you ever used hormone therapy? _____Yes _____No	
Periods come every _____days	Number of days of flow:_____

Questions about your Period	**Yes**	**No**	**Are your periods:**
Was your most recent period normal?			____light
Do you think you may be pregnant?			____moderate
Do you ever miss periods?			____heavy
Do you ever bleed between periods?			____ clots

Do you take medication for pain?

Name of Medication:

SEXUAL AND CONTRACEPTIVE HISTORY

Are you sexually active? □ Yes □ No

Sexual Orientation: ___Bisexual ___Heterosexual ___Homosexual ___Transgender

Partner(s) ____Male ___Female ___Both

Are you using birth control now? □ No □Yes : Type:
___Condoms ___Depo Injections ___Diaphragm
___ IUD ___Nexplanon ___Nuvaring
___Patch ___Tubal Ligation ___Vasectomy
___Pills *Name:*_____

PLEASE CHECK ALL CONTRACEPTIVE METHODS USED BY YOU OR YOUR PARTNER

√	**Type**	**Date Used**
	Pills	
	IUD/Coil	
	Diaphragm	
	Tubal Ligation	
	Vasectomy	
	Other	

CONTRACEPTIVE METHOD PROBLEMS

Yes	No	**BIRTH CONTROL PILL**
		Headaches
		Blurred, double vision
		Pain, swelling of legs
		Chest pain, shortness of breath
		Abdominal pain
		Jaundice
		Severe depression
		IUD
		Abdominal pain
		Unusual vaginal bleeding
		Fever or chills
		DIAPHRAGM
		Unusual vaginal discharge
		Discomfort
		Urinary tract infections

PAP SMEAR/EXAM/PROBLEMS

Date of last pap smear:_____ Result_____

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