Main Line Health® | BEHAVIORAL HEALTH

Women's Emotional Wellness Center (WEWC) Medical Questionnaire

Patient Name: _____ **Date**: _____

Primary Care Physician: _____

Address and Telephone: _____

_____

Obstetrician (if applicable): _____

Address and Telephone: _____

_____

_____

Are you currently pregnant? ☐ **Yes** ☐ **No**

Number of pregnancies: _____ **Number of living children**: _____

Have you had your thyroid checked recently? ☐ **Yes, date**: _____ ☐ **No**

If yes, outcome: ☐ **Normal** ☐ **Abnormal, Comments**: _____

Have your iron levels been checked recently? ☐ **Yes, date**: _____ ☐ **No**

If yes, outcome: ☐ **Normal** ☐ **Abnormal, Comments**: _____

Please list any known allergies: _____

Please list any medications you are currently taking:

_____

Medication, Dose, Frequency

_____

Medication, Dose, Frequency

_____

Medication, Dose, Frequency

_____

Medication, Dose, Frequency

Who prescribes your medications? _____

Do you feel safe at home? ☐ **Yes** ☐ **No**

Are you currently working? ☐ **Yes** ☐ **No** ☐ **On FMLA, scheduled to return date**: _____

If employed, Employer/Title: _____

Condition	Are you currently or have you in the past, experienced any of the following?	Current	Past	Receiving Medical Care?	Please Explain
Anemia	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Thyroid Disease	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Other Immune Diseases	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Hypertension	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Hypotension	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Please continue to next page					

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Condition	Are you currently or have you in the past, experienced any of the following?	Current	Past	Receiving Medical Care?	Please Explain
Ulcer	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Pancreatitis	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
GI Bleeding	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Seizure Disorder	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Heart Attack	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Eating Disorder	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	
Problems with Drugs or Alcohol	☐ Yes ☐ No	☐	☐	☐ Yes ☐ No	

Family History

Family Member	Living or Deceased	Medical Conditions	Please Explain
Mother		☐ Yes ☐ No	
Father		☐ Yes ☐ No	
No. Brothers:	# Living _____ # Deceased _____	☐ Yes ☐ No	
No. Sisters:	# Living _____ # Deceased _____	☐ Yes ☐ No	

Patient Signature: _____ **Date**: _____