



Confidential Medical Questionnaire

Date Patient Name Date of Birth Age

Sex: Male Female Transgender How do you like to be identified

How did you hear about us?:

Are your immunizations up to date? Are you allergic to latex

Please list any allergies and your reaction

Please list any medications your are currently taking

Have you traveled outside the United States within the last 30 days? Yes No

If yes: Where?

Dates?

FAMILY HISTORY

Any family members (blood relative) have/had the following:

Cancer	Type	Relationship
Bleeding Disorder		Relationship
Blood Clot Disorder		Relationship
History of DVT/PE (Blood clots in legs and/or lungs)		Relationship
Cardiovascular (Heart Attack, Stroke, High Blood Pressure)		Relationship
Heart Disease (Valve Disease, Cholesterol, Heart Murmur)		Relationship
Genetic Disorders		Relationship
Diabetes		Relationship
Other		

Social History

Married Never Married Divorced Separated Widowed Partnered

What is your current or past occupation?

Tobacco (specify type)	How much	How often
Drug (specify type)	How much	How often
Alcohol (specify type)	How much	How often

Have you ever been a victim of violence and/or sexual abuse?

Symptoms

Do you have any of the following symptoms (Please circle):

Constitutional

Cardiovascular

Respiratory

Breasts

Skin/Lymph

Gastrointestinal

Genitourinary

Musculoskeletal

Neurological

Psychiatric

Past Medical History

Are you currently under the care of another medical provider?

If yes, who:

Do you have or have you ever had problems with the following?

Cardiovascular

High Blood Pressure
Stroke
Heart Murmur
Increased Cholesterol
Other

Breast

Previous Biopsy
Last Mammogram
Abnormal Mammogram

Cancer

What type
When
Treatment Given

Genetic Disorders

BRCA Gene
Sickle Cell
G6PD
Other

GI Problems

Crohn's Disease
Gallblader
Irritable Bowel
Gastritis
Hepatitis
Other

GU Problems

Fibroids
Ovarian Cysts
Endometriosis
Ectopic Pregnancy
PCOS
Frequent UTIs
Other

Metabolic

Diabetes (specify 1 or 2)
Gestational Diabetes
Thyroid Disease
Other

Hematologic

Anemia
Blood Clots (legs or lung)
Bleeding/Blood Clot Disorder
Other

Neurologic

Seizures
Headaches
Migraines with Aura
Migraines without Aura
Other

Respiratory

Asthma
COPD
Other

Psychological

Depression
Anxiety
Bipolar
Other

STD

Type of STD
Last Treated

Autoimmune Disease (Lupus)
Blood Transfusion

Please list any surgical history, including type, date and reason:

Sexual History

Are you currently sexually active? Date of last intercourse: Is your partner: Male Female Both

Type of sexual activity: Genital Oral Both Current number of partners: Number of partners in the last 12 months:

Partner History Does your partner have sex with: Male Female Both Does your partner have a history of IV drug use:
How many other sexual partners Condom Use: Never Sometimes Always

Women's Health History

Age of first period First day of your last menstrual cycle How often do you have your period

How long do you bleed Are your periods: heavy medium light clots

Do you have painful period (cramps)? If yes are the cramps: severe mild

When was your last pap smear?

Have you ever been tested for HPV? Have you had a biopsy or colposcopy? Did you receive treatment?

Have you received the HPV vaccine? If so when Did you receive all 3 parts of the vaccine

Obstetrical History

Have you ever been pregnant: Age of your first pregnancy:

Please list the number of each type of pregnancy: Full-Term Premature Miscarriages Terminations Ectopic

How many living children do you have? Date of your last pregnancy: Do you want future pregnancies?

Are you currently breastfeeding?

What is your plan for pregnancy?

Are you doing anything now to prepare for pregnancy?

Contraceptive History

Current Method of Birth Control: How long have you used this method:

Have you had problems with any previously used birth control: If yes, please describe:

Does your current method of birth control match your desire for pregnancy:

What kind of birth control would you like today:

Patient Name (Please Print)

Patient Signature

Date