Medical Health Questionnaire

Patient name: _____ Date: _____

Age: _____ No of deliveries: _____ Vaginal Deliveries _____ C/S_____

What is the problem which brought you to see the doctor?

_____ Have

you had any treatments for this problem?

_____

Medical health

Gynecology: Check the boxes which apply to you

☐ Hysterectomy If yes, abdominal ☐ or vaginal ☐

☐ Menopause If yes, how long ago? _____

☐ Still having periods. If yes, regular ☐ Irregular ☐

Flow normal ☐ Flow heavy ☐

PAP smears ☐ Recent Not recent ☐

☐ Always normal Abnormal in ☐ past

Nature of PAP Abnormality and Treatment

_____

☐ Other pelvic surgery. If yes, what did you have done?

_____

Surgery

List surgical procedures you have had and why?

Procedure Reason

_____

_____

Medical Problems List any medical problems

_____

_____

Patient name: _____

Medications and Allergies

Medications. List your medications including the dose and times taken.

_____

_____

_____

Allergies ☐ No ☐ Yes. If yes, list them below

_____

_____

Social History:

Are you a smoker? ☐ No ☐ Yes. If yes, how much per day

How many caffeinated drinks per day do you drink? (Include coffee/tea/colas)

_____

How many alcoholic drinks do you drink per week?

_____

Are you currently working? If so, what is your occupation?

_____

Other information

Family Physician Name: _____

Family Physician Phone number: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Email: _____