

CONFIDENTIAL PATIENT MEDICAL HISTORY QUESTIONNAIRE

REASON FOR VISIT

ALLERGIES (Please specify)

PAST MEDICAL AND FAMILY HISTORY

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

	SELF		FAMILY			SELF		FAMILY			SELF		FAMILY	
WT. LOSS-GAIN	<input type="checkbox"/>	<input type="checkbox"/>			BOWEL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>			THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>		
HEADACHE/MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>			URINARY INCONTINENCE	<input type="checkbox"/>	<input type="checkbox"/>			PEPTIC ULCER (STOMACH)	<input type="checkbox"/>	<input type="checkbox"/>		
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>			URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>			HIATAL HERNIA (REFLUX)	<input type="checkbox"/>	<input type="checkbox"/>		
Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>			BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>			JAUNDICE/HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Disease	<input type="checkbox"/>	<input type="checkbox"/>			ANEMIA/BLOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>			KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>		
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>			VAR. VEINS/PHLEBITIS	<input type="checkbox"/>	<input type="checkbox"/>			ANXIETY/DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>		
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>			DIABETES	<input type="checkbox"/>	<input type="checkbox"/>			OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>		
RESPIRATORY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>			BREAST DISEASE	<input type="checkbox"/>	<input type="checkbox"/>			EPILEPSY/NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>		
Pulmonary(Lung)					CANCER (Specify Type)	<input type="checkbox"/>	<input type="checkbox"/>							

Do you exercise _____yes _____no

COMMENTS:

PAST HOSPITAL ADMISSIONS

List those operations and serious illness' which required hospitalization (**Excluding Pregnancy**)

YEAR	REASON FOR ADMISSION/HOSPITAL	YEAR	REASON FOR ADMISSION/HOSPITAL
1.		3.	
2.		4.	

MEDICATIONS

List BELOW all medications you are CURRENTLY taking (dosage/frequency) INCLUDE over-the-counter drugs

MENSTRUAL HISTORY

First Period (AGE) _____
 Date of last period _____
 Presently menstruating, state 1st day _____
 Period Interval (How often?) _____
 Duration of Bleeding (# of Days) _____
 HOW MANY PERIODS IN THE LAST YEAR? _____

MENSTRUAL PAIN/CRAMPS

MILD
 MODERATE
 SEVERE
 Always Present
 BLEEDING/SPOTTING BETWEEN PERIODS? Yes No

MEDICATIONS FOR CRAMPS?

Yes No

MENOPAUSAL HISTORY (If Applicable)

HOT FLASHES? Yes No TREATMENT? Yes No

VAGINAL INFECTION(S) HISTORY OF ...	YEAST <input type="checkbox"/>	TRICHOMONAS <input type="checkbox"/>	CHLAMYDIA <input type="checkbox"/>	HERPES <input type="checkbox"/>
	GONORRHEA <input type="checkbox"/>	BACTERIAL VAGINOSIS <input type="checkbox"/>	GENITAL WARTS <input type="checkbox"/>	

MAMMOGRAM/LAST DATE NORMAL ABNORMAL DO YOU DO MONTHLY SELF-BREAST EXAMS? Yes No

PAP TEST/LAST DATE NORMAL ABNORMAL

CONTRACEPTIVE HISTORY OF ...	CURRENT METHOD?	PAST METHODS USED?	IF PILL, WHAT BRAND? (If applicable)
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OBSTETRICAL (State Number)	PREGNANCIES	PREMATURE	MISCARRIAGES	ABORTIONS	CHILDREN LIVING				
DOB	WKS PREG	BIRTH WT	SEX	DEL TYPE	DOB	WKS PREG	BIRTH WT	SEX	DEL TYPE
1.					3.				
2.					4.				

SOCIAL HISTORY

Do you SMOKE ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how much daily?	How many years?	QUIT?
Do you drink ALCOHOL ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how much?	How often?	
Do you use street DRUGS ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what type?	How often?	
Do you use CAFFEINE ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what type?	How much daily?	

SEXUAL HISTORY

Yes No Have you ever had vaginal intercourse (sex)? Are you sexually active now? Yes No
 Yes No Have you recently had sex with a new partner? If yes, was your last partner Male Female
 Yes No Have you ever had intercourse against your will? Number of lifetime partners? _____
 Yes No Have you previously or currently been abused by your partner?

COMMENTS

PHYSICIAN

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 _____