



HENRY FORD MACOMB
OBSTETRICS & GYNECOLOGY

Medical History Questionnaire

Name: _____

Today's Date: _____

Birth date: _____

Age: _____

Reason for Visit

Obstetric History

How many times have you been pregnant? _____

How many live births? _____ miscarriages or abortion? _____

How many were vaginal deliveries? _____ How many were Cesarean Section? _____

Any complications with your pregnancy, labor or delivery? _____

Menstrual History

First day of last period? _____ Are you past menopause? _____ If yes, since what age? _____

Do you have: hot flashes / night sweats / vaginal dryness (If yes, Mild / Moderate / Severe)

Are you having difficulties with your period? _____ If yes, for how long? _____

Are your periods regular? _____

Usual number of days of bleeding each cycle: _____ Type of flow: Light / Moderate / Heavy

Do you experience: _____ Bleeding during or after intercourse?
_____ Spotting/bleeding between periods?

Do you require dual protection? _____
_____ two pads _____ tampon & pad _____ protection for bedding

Pain with periods? _____ If yes, describe the severity of the pain on a scale of 0-10, with 10 being the worst possible pain (Circle one) 0 1 2 3 4 5 6 7 8 9 10

What do you take for your pain with your periods? _____

Name: _____

Birth date: _____

Contraceptive History

Have you ever been sexually active? _____ Are you currently sexually active? _____

Are you planning on having a child / more children? _____

Do you currently use a family planning method? _____ If so, what method do you use?

- | | | |
|--|---------------------------------|----------------------|
| _____ Diaphragm | _____ Withdrawal | _____ Condoms |
| _____ Implanon | _____ Birth Control Pills | _____ Depo Provera |
| _____ Natural Family Planning (rhythm) | _____ Intrauterine Device (IUD) | _____ Tubal Ligation |
| | | _____ Vasectomy |

Gynecologic History

Do you **currently** have any of the following:

- | | | | |
|---|---------------------|--------------------------------|-------------------|
| _____ Uterine fibroids | _____ Endometriosis | _____ Infertility | _____ Pelvic pain |
| _____ Severe pre-menstrual symptoms (explain) | | _____ Falling organs (explain) | |
- _____
- _____

Have you **ever** had any of the following?:

- _____ Sexually transmitted disease. If yes, what type and when (year)? _____
- _____ Infection in fallopian tubes (PID) _____

_____ Significant difficulty with breast pain Breast biopsies: _____

Have you had a mammogram? _____ Date of last mammogram: _____

Ever had an abnormal mammogram? _____ Explain: _____

Date of last pap smear: _____ Were you told it was abnormal? _____

Have you ever had an abnormal pap? _____ Explain: _____

Have you ever had treatment on your cervix with:

- _____ Cryotherapy _____ LEEP _____ Laser

Do you experience pain with intercourse? _____ If yes, describe the severity of the pain on a scale of 0-10, with 10 being the worst possible pain (Circle one) 0 1 2 3 4 5 6 7 8 9 10

_____ With insertion only _____ Deep intercourse only _____ Entire act of intercourse

Name: _____

Birth date: _____

Medical/Surgical History

Do you or did you ever have:

Arthritis	yes	no	Diabetes	yes	no
Blood Disorder	yes	no	Depression/anxiety disorder	yes	no
Asthma	yes	no	Migraine Headaches	yes	no
Tuberculosis	yes	no	Stroke	yes	no
Emphysema	yes	no	Seizure Disorder	yes	no
Heart Disease	yes	no	Other Neurologic Disorders	yes	no
Heart Attack	yes	no	High Cholesterol	yes	no
High Blood Pressure	yes	no	Ulcer	yes	no
Low Thyroid	yes	no	Irritable Bowel Syndrome	yes	no
Liver Disease	yes	no	Crohn's Disease/Ulcerative Colitis	yes	no
Kidney Disease	yes	no	Breast Cancer	yes	no
Blood clots in your lungs/legs	yes	no	Other Cancer	yes	no
Do you require antibiotics With dental procedures?	yes	no	What type?		

Any other medical problems? _____

Please list any surgeries (include the year or your age at the time): _____

Can you bathe and dress yourself? _____

Do you need assistance to walk? _____

Allergies to Medications (Please list medication and reaction to the medication) None _____

Family History

Has anyone in your family had:

			Who?				Who?
Breast Cancer	yes	no		Diabetes	yes	no	
Colon Cancer	yes	no		High blood pressure	yes	no	
Uterine Cancer	yes	no		Heart disease or heart attack	yes	no	
Ovarian Cancer	yes	no		Osteoporosis	yes	no	
Other cancer (explain)	_____			Any other family medical problems?			
	_____			_____			
	_____			_____			

Name: _____

Birth date: _____

Nutrition History

What is your height: _____ Any significant weight gain or loss in past year? yes no
If yes, circle: Gain or Loss

Are you allergic to any food? Describe _____ yes no

Do you have chewing, swallowing, or mouth problems that make it hard to eat? yes no

Are you able to afford adequate food? yes no

Are you able to shop, cook, or feed yourself? yes no

Do you take nutritional supplements? yes no

Personal and Social History

Are you:
____ Married ____ Single ____ Separated ____ Divorced ____ Widowed

Are you:
____ Employed ____ Retired What is your occupation? _____

Do you:
____ Live alone ____ In a house ____ In an apartment Other _____

Do you smoke? ____ Yes ____ No If yes, how much? _____
If quit, for how long? _____

Do you drink alcohol? ____ Yes ____ No How often? _____
How much? _____

Do you use drugs? ____ Yes ____ No How often? _____
What kind? _____

Do you get regular exercise? ____ Yes ____ No How often? _____
What type? _____

What is your preferred method of learning? written verbal visual

Have you appointed a patient advocate (through a durable power of attorney or living will) to make health decisions for you if you become incapacitated? ____ Yes ____ No
If not, would you like to know more about how to do so? ____ Yes ____ No

Name: _____

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Do you have any religious/cultural objections to any traditional medical procedures?
 Yes No

Have you suffered from physical, sexual or mental abuse? Yes No

Have you ever felt threatened by anyone? Yes No

Have you ever harmed yourself or thought about harming yourself? Yes No

Have you ever had suicidal thoughts? Yes No

Do you currently have suicidal thoughts? Yes No

Name: _____

Birth date: _____

Bladder Symptom Questionnaire (Please complete only if this applies to you)

Circle T for true and F for false

T F I leak urine. If true, how long have you leaked urine? _____

T F I have to wear pads because of losing urine. If yes, for how long? _____
_____ Only when leaving the house _____ Daily _____ While sleeping
_____ Pantyliner _____ Absorbent Pad _____ Absorbent garment

T F I have had an operation on my bladder. The operation I had on my bladder...
_____ Was a vaginal procedure _____ Was an abdominal procedure
_____ Was both abdominal and vaginal _____ Helped my problem for a short time
How long? _____
_____ Cured my problem _____ Did not help at all

T F I leak urine when I cough, sneeze, exercise, or move suddenly.

T F I often feel the urge and need to urinate even if my bladder isn't very full.

T F I often leak when I am trying to make it to the toilet.
_____ Small dribble _____ Moderate amount _____ Large amounts

T F I have leakage with urgency
_____ Once a week _____ Once a day _____ Multiple times a day

Which is worse?

_____ Leakage with coughing/exercise _____ Leakage with urge _____ Both are equally severe

T F While awake, I urinate more than six times per day.

T F The need to urinate wakes me up two or more times during the night. If true, how many times on average? _____

T F I have had two or more bladder infections in the past 12 months.

T F I have been treated with urethral dilatation. How many times? _____

T F I have trouble with bed-wetting.

T F My urine loss is a continual drip, so I am constantly wet.

T F I have trouble starting the urine stream.

T F My urine stream is no more than a dribble.

T F After I urinate, I often feel I haven't completely emptied.

Name: _____

Birth date: _____

Recurrent Bladder Infections (Please complete only if this applies to you)

In your own words, what symptoms are associated with your urinary tract infections? _____

How frequently do you have urinary tract infections? _____

Have your urinary tract infections been proven by “cultures” of your urine? _____ Yes _____ No
_____ Don't know

How long after taking antibiotics do you notice improvement? _____

How long before your symptoms are completely gone? _____

Do you notice an association of your infections to intercourse? _____ Yes _____ No

Do you have frequent vaginal infections? _____ Yes _____ No

Do you have lumbar disc disease? _____ Yes _____ No

Have you ever been told you had problems with your kidneys? _____ Yes _____ No