Medical History Questionnaire

Patient Name: ____

Date of Birth: ____________________

Current Medical Problems

Problem

Surgical History

Procedure	Date

Current Medications

Medication Name	Dose

Allergies to Medications/Latex

Drug/Allergen	Reaction (i.e. rash, etc.)

Past Medical History

Condition/Problem	✓	Notes:	Condition/Problem	✓	Notes:
Anemia			Heart Conditions		
Anesthesia Complications			Heart Disease		
Anxiety Disorder			Hepatitis		
Arthritis			High Blood Pressure		
Asthma			Hypertension		
Birth defects or inherited disease			Infertility		

Condition/Problem	✓	Notes:	Condition/Problem	✓	Notes:
Breast Cancer			Kidney Disease		
Breast problem			Kidney or Bladder Problem		
Cancer			Lung Disease		
Depression			Ovarian Cancer		
Diabetes			Psychiatric Illness		
Endometriosis			Thyroid Problems		
GI problems			Varicosities		
Headaches/Migraines					

Social History

Alcohol Intake	
Do you smoke?	
If yes, how much?	
Tobacco- Years of use	
Illicit drugs	

Family History

Relation	Illness/Problem	Notes:

GYN History

How long does your period last (days)?	
Last Menstrual Period	
How often do you get your cycle?	
Flow (Circle one)	Light, moderate, heavy
Age at Menarche	
Current Birth Control Method	

Obstetric History

Total # of pregnancies	# of Preterm Deliveries	# of Abortions	# of Miscarriages	# of Ectopic Pregnancies	# of Living Children

Patient Signature Date