Women's Health
OF THE EMERALD COAST

Medical History Questionnaire

Date:________________

Name	Date of Birth	Age	Weight	Height
Pharmacy	Primary Care Physician			
Reason for your visit (Chief Complaint)	Date problem began:	Have you had this before?	If so when?	

Social History

- Marital Status ▫ Single ▫ Married ▫ Widowed ▫ Divorced ▫ Separated
- Drug/Alcohol Use ▫ Yes ▫ No #Drinks per week_____
- Current Smoker ▫ Yes ▫ No Cigarettes per day_____
- Former Smoker ▫ Yes ▫ No
- Never Smoked ▫
- Do you exercise? ▫ Yes ▫ No
  What type?___________________
- Do you consume Caffeine? ▫ Yes ▫ No
  What type?_____________
- Highest Level of Education__________________________
- Employment (include job title)_______________________
- Race ▫ Caucasian ▫ African American ▫ Hispanic ▫ Asian American ▫ Other
- Ethnicity ▫ Latino/Hispanic ▫ Other ▫ Refused

Surgical and Hospitalization History

Please list all surgeries and hospitalizations with dates.

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Medication	What are you taking for? (ex: hypertension)	Dosage & How often do you take?	How long have you taken?	Allergies	Reaction
				Medications Causing Adverse effects	

Obstetic History			
Number of Pregnancies	Number of Vaginal Deliveries	Number of Cesarean Deliveries	Largest Baby Weight
Forceps or Vaccum Used ▫Yes ▫No Episiotomy ▫Yes ▫No	Laceration/Tear ▫Yes ▫No Degree/Details:	Other Complications or prolonged Labor:	
Gynecologic History	Date of last PAP smear: Normal?	Date of last Mammogram: Normal?	Are you sexually active? ▫Yes ▫No

Date of Last Menstrual Period:	Do you perform monthly self breast exams? ▫Yes ▫No	Have you ever used a pessary? ▫Yes ▫No	Have you ever had an abnormal Pap smear or HPV? ▫Yes ▫No
Have you ever had a sexually transmitted disease? If yes when?		Are you using Contraception? If so what type?	
Do you experience any of the following? Check what applies ▫bleeding between periods ▫heavy menstrual periods ▫pain with periods ▫pain with intercourse ▫bleeding after intercourse ▫"falling" of pelvic organs or prolapse ▫post menopausal bleeding ▫Vaginal Dryness ▫Leakage of Urine ▫Bowel Incontinence			
Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, list medication, dose and route.		If you have had a Hysterectomy please check the organs that were removed and how they performed the operation: ▫Uterus ▫Cervix ▫R Ovary ▫L Ovary ▫R Fallopian Tube. ▫L Fallopian Tube ▫Vaginal ▫Abdominal ▫Laparoscopic ▫Robotic	

Family History	Yes	No	Parent/Grandparent/ Sibling/Children	Family History	Yes	No	Parent/Grandparent/ Sibling/Children
Breast Cancer				High Blood Pressure			
Ovarian Cancer				Obesity			
Cervical Cancer				Hyperlipidemia			
Uterine Cancer				Pulmonary Embolism			
Colon Cancer				Blood clots			
Heart Attack				Osteoporosis			
Stroke				Alzheimer's Disease			
Diabetes				Mental Illness			
Any other Family History:							

Do you have any of the following conditions								
Conditions:	Yes	No	Conditions:	Yes	No	Conditions:	Yes	No
Night Sweats			Memory Loss			Weight Change		
Hot Flashes			Anxiety			Fatigue		
Decreased Sexual Desire			Depression			Short of Breath		
Bladder Infection			Frequent Headaches			Bloody Stool		
Thyroid			Diabetes			Blood Clot		

Any Additional Information We may need:		
I ________________________certify that the above information is correct to the best of my knowledge. I will not hold Women's Health of the Emerald Coast or staff responsible for any errors that I have made in completing this form.		
Patient Signature	Date	Reviewed by