THE SINAI INSTITUTE FOR FEMALE PELVIC MEDICINE

MEDICAL HISTORY QUESTIONNAIRE

Name	Date of Birth Age	Drug Allergies
Please describe the reason for your visit (chief complaint)		

OBSTETRIC HISTORY

Number of Pregnancies	Number of Full Term Pregnancies:	Pre-term Deliveries
Living Children	Vaginal Deliveries	Cesarean Deliveries

GYNECOLOGIC HISTORY

Date of last menstrual period:

Date of last PAP smear: Normal?

Date of last mammogram: Normal?

Have you ever had a sexually transmitted disease? If yes, when?

Are you sexually active at the present time?

Are you using contraception? If yes, what type?

Do you experience any of the following? (check ones you have)

_____ Bleeding between periods
_____ Heavy menstrual periods
_____ Pain with periods
_____ Bleeding after intercourse
_____ Pain with intercourse
_____ "Falling" of pelvic organs or prolapse

Are you presently taking, or have you taken in the past, hormone replacement therapy? If yes, medication and dose schedule, vaginal/oral:

MEDICATIONS AND MEDICAL CONDITIONS

Medication	**Dose**	**How often you take**	**Reason for Medication use (e.g. High Blood Pressure)**

PAST MEDICAL HISTORY

Please describe your past experience with all medical conditions, operations, serious injuries, hospitalizations and related treatments. Please include dates (month/year) of any surgeries.

FAMILY HISTORY

Are there medical events in your family's history, including diseases that may be hereditary or place you at risk?

Yes	Condition	Yes	Condition	Yes	Condition
	High blood pressure		Heart disease		Thyroid disease
	Stroke		Diabetes		Asthma
	Kidney disease		Liver disease		Breast disease
	Cancer (indicate type)				
	Other				

SOCIAL HISTORY

Marital Status	Drug/Alcohol Use: Yes No	Tobacco Use: Yes No
Single Married Widowed Separated Divorced	Drinks/week	Cigarettes/day

Highest Level of Education	Employment (please include job title)

Race

Caucasian African American Hispanic Asian American Other

REVIEW OF SYSTEMS

Do you have or have you had any serious or chronic medical conditions?

	Yes		Yes		Yes		Other
Constitutional		Weight change		Fatigue			
Eyes		Vision changes		Cataracts		Glaucoma	
Ears/Nose/Mouth/Throat		Ulcers		URI			
Cardiovascular		Chest pain		Orthopnea		DOE	
Respiratory		SOB		Wheezing			
Gastrointestinal		Nausea/Vomiting		Diarrhea		Bloody stool	
Musculoskeletal		Weakness					
Integumentary/Skin		Rash					
Neurological		Seizure		Syncope		Neuropathy	
Psychiatric		Depression		Anxiety			
Endocrine		Hot flashes		Diabetes		Thyroid	
Hematologic/Lymphatic		Easy bruising		Bleeding		Adenopathy	
Allergic/Immunologic		Seasonal					

Patient Signature

Date