Medical History Questionnaire

avina women's care™

Date of Visit: ____ /____ /____ Patient Name: _____ Date of Birth: ____ /____ /____

Primary Care Physician: _____ Patient Type: ☐ New Patient ☐ Current Patient (seen in past 3 years)

Reason for Visit: ☐ Annual/Preventative Exam ☐ OB Exam ☐ GYN Exam Problem: _____

☐ Other: _____

Pregnancy History

Number of: Pregnancies _____ Full Term Deliveries _____ Premature Deliveries _____

Miscarriages _____ Ectopics: _____ Abortions _____ Living Children _____

1. Delivery Date (year): _____ Gender (circle): M / F Birth Weight: _____ Weeks at delivery: _____
   Delivery Type (circle): Vaginal / C-section Complications: _____

2. Delivery Date (year): _____ Gender (circle): M / F Birth Weight: _____ Weeks at delivery: _____
   Delivery Type (circle): Vaginal / C-section Complications: _____

3. Delivery Date (year): _____ Gender (circle): M / F Birth Weight: _____ Weeks at delivery: _____
   Delivery Type (circle): Vaginal / C-section Complications: _____

Additional Pregnancies: _____

Menstrual History

Age of first menstrual period: _____ Regular monthly cycles? (circle): Yes / No / N/A

First day of last period : _____ /_____ /_____ Current Method of contraception: _____

History of STDs: _____

Preventative Care

Last Pap Smear: _____ /_____ /_____ Previous Abnormal Pap? (circle): Yes / No Gardasil Vaccine? (circle): Yes / No

Last Mammogram: _____ /_____ /_____ Previous Abnormal Mammogram? (circle): Yes / No

Last Cholesterol Test: ____ /____ /____ Last Colonoscopy: ____ /____ /____ Last DEXA (Bone Density): ____ /____ /____

Current Medications (Including Over-the-Counter and Vitamins)

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Allergies (Drugs and/or Food)

Type: _____ Reaction: _____

Type: _____ Reaction: _____

Type: _____ Reaction: _____

Surgeries and/or Major Injuries

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Social History

Regular Exercise? (circle): Yes / No Times per week: _____

Caffeine Intake? (circle all that apply): Coffee / Tea / Soda / Energy Drinks / None Servings per day: _____

Alcohol Intake? (circle): Yes / No If yes, type: _____

Tobacco Use? (circle): Yes / No / Former Smoker If yes, how much: _____

Recreational drug use? (circle): Yes / No

Medical History

Check box if you have a history of:

- ☐ Abnormal Pap Smear
- ☐ Autoimmune Disease
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Genital Warts
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse / Heart Disease
- ☐ Neurologic Disorder
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ Polycystic Ovarian Disease
- ☐ Pulmonary Embolism / DVT
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Uterine Fibroids
- ☐ Other _____

Family History

Check box and list relation (e.g. mother, father, brother, sister, etc.):

- ☐ Alcoholism _____
- ☐ Autoimmune Disorder _____
- ☐ Birth Defects _____
- ☐ Blood Clots _____
- ☐ Breast Cancer _____
- ☐ Cerebral Palsy _____
- ☐ Cervical Cancer _____
- ☐ Colon Cancer _____
- ☐ Cystic Fibrosis _____
- ☐ Diabetes _____
- ☐ Endometrial Cancer _____
- ☐ Epilepsy _____
- ☐ Genetic Disorder _____
- ☐ Heart Disorder _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Kidney Abnormalities _____
- ☐ Liver Disease _____
- ☐ Mental Health Disorder _____
- ☐ Osteoporosis _____
- ☐ Ovarian Cancer _____
- ☐ Pancreatic Cancer _____
- ☐ Sickle Cell Disease _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Uterine Cancer _____
- ☐ Other _____

Symptoms

Check box if you have any of these symptoms:

<u>Reproductive & Urinary Symptoms</u>

- ☐ Abnormal Bleeding
- ☐ Bleeding After Sex
- ☐ Bleeding Between Periods
- ☐ Bleeding Post Menopause
- ☐ Blood in Urine
- ☐ Burning Urination
- ☐ Hot Flashes
- ☐ Menstrual Cramps
- ☐ Night Sweats
- ☐ Painful Intercourse
- ☐ Pelvic Pain
- ☐ Sexual Difficulties
- ☐ Urinary Incontinence
- ☐ Urination Frequency / Urgency
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Other _____

<u>General Symptoms</u>

- ☐ Blood in Stool
- ☐ Breast Mass/Discharge
- ☐ Chest Pain/Palpitations
- ☐ Constipation
- ☐ Cough
- ☐ Depression/Anxiety
- ☐ Diarrhea
- ☐ Dizziness/Fainting
- ☐ Easy Bruising
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Jaundice/Liver Disease
- ☐ Muscle/Joint Pain
- ☐ Nasal Drainage
- ☐ Nausea/Vomiting
- ☐ Numbness/Tingling
- ☐ Shortness of Breath
- ☐ Swollen Legs
- ☐ Varicose Veins/Clots
- ☐ Weight Changes
- ☐ Wheezing
- ☐ Other _____