Lifetime Women's Healthcare

# MEDICAL QUESTIONNAIRE

| Full Name: | Date: |
|---|---|

| Date of Birth: | | Age: | |
|---|---|---|---|
| Number of Pregnancies: | | Live Births: | |
| Abortions: | Miscarriages: | Preterm deliveries: | |
| Marital Status: | Nationality: | Occupation: | Height: |

| **QUESTIONS** | **NO** | **YES** | **EXPLANATION** |
|---|---|---|---|
| Are you allergic to any medications? | | | |
| Are you taking any medications, vitamins or natural remedies? If yes, please list them. | | | |
| **DO YOU HAVE ANY OF THE FOLLOWING:** | | | |
| **QUESTIONS** | **NO** | **YES** | **EXPLANATION** |
| | | | |
| Diabetes? | | | |
| High blood pressure? | | | |
| Asthma/Lung disease, tuberculosis? | | | |
| Heart problems, defects or murmurs? | | | |
| Thyroid disease? | | | |
| Epilepsy? | | | |
| Cancer? | | | |
| Other chronic disease? | | | |
| Have you ever had a blood transfusion? | | | |
| Did you have diabetes or hypertension when pregnant? | | | |
| Have you had your routine vaccinations for the flu, hepatitis, tetanus, etc? | | | |
| Have you had surgeries before? (C/section, D&C, etc...) | | | |
| | | | |

| QUESTIONS | NO | YES | EXPLANATION |
|---|---|---|---|
| When was your last pap smear? | | | |
| Have you had an abnormal mammogram? If yes, indicate the date. | | | |
| When was your last mammogram? | | | |
| When was you last physical exam? | | | |
| Are your periods irregular? | | | |
| When was your last menstrual cycle? | | | |
| Does your menstrual cycle last more than 7 days? | | | |
| Do you use 6 or more pads or tampons per day during your period> | | | |
| Are you sexually active? | | | |
| Do you use birth control? If yes, which one? | | | |
| Do you exercise regularly? If yes, indicate what type of exercise and how often. | | | |
| Do you use caffeine? Including soda and energy drinks. If yes, indicate what type and how much? | | | |
| Do you smoke? If yes, at what age did you started and how much do you smoke? | | | |
| Are you an ex-smoker? If yes, when did you quit and for how long did you smoke for? | | | |
| DO you drink or did you use to drink alcoholic beverages? If yes, indicate type of drink and frequency. | | | |
| Do you use or did you used drugs before? If yes, indicate type of drug and frequency. | | | |
| Does your partner or previous partners ever had a homosexual relationship or used IV drugs? | | | |
| Have you had more than 1 sexual partner? | | | How many this year?<br>How many in lifetime? |

**Have any of your PARENTS, GRADNPARENTS OR SIBLINGS had any of the following illnesses?**

| QUESTIONS | NO | YES | EXPLANATION |
|---|---|---|---|
| Diabetes? | | | |
| High blood pressure? | | | |
| Cancer? | | | |

| QUESTIONS | NO | YES | EXPLANATION |
|---|---|---|---|
| Heart attacks, heart disease? | | | |
| Stroke? | | | |
| Hepatitis? | | | |
| Asthma? | | | |
| Epilepsy? | | | |
| Thyroid disease or blood disorders? | | | |
| Fibrosis or endometriosis? | | | |
| Difficulty with anesthesia? | | | |
| Sickle cell trait or sickle cell disease?? | | | |
| **Have YOU had any of the following illnesses recently?** | | | |
| **QUESTIONS** | **NO** | **YES** | **EXPLANATION** |
| Unexplained fevers? | | | |
| Change in texture of skin or hair? | | | |
| Problems with ear, nose or throat? | | | |
| Problems with swallowing? | | | |
| Trouble breathing? | | | |
| Breast lumps, pain or discharge from the breast?? | | | |
| Dizzy spells or faints? | | | |
| headaches? | | | |
| Bleeding disorders? Easy bruising? | | | |
| Chronic cough? | | | |
| Urinary burning or incontinence with cough? | | | |
| Black, tarry stools or blood or mucous in the stool? | | | |
| Trouble with sexual relations, intimacy or arousal? | | | |
| Suicidal thoughts? | | | |
| Depression, anxiety, schizophrenic disorders? | | | |
| Mental of physical abuse by spouse or family? | | | |
| High-risk behavior for sexually transmitted diseases? | | | |

**Office use only. Reviewed by:_____Date:_____**

# QUESTIONNAIRE: PREGNANT PATIENTS

Please list your previous pregnancies. Type of deliveries including; miscarriages, abortions, pregnancies in tubes, premature, cesarean, vaginal.

| Date Pregnancy Ended | Type of Delivery | Baby's Weight | Baby's Sex | Length of Labor | Complications |
|---|---|---|---|---|---|

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

| QUESTIONS | NO | YES | IF YES, PLEASE EXPLAIN |
|---|---|---|---|
| Have you had high blood pressure, diabetes, or preterm birth symptoms with any of your pregnancies? | | | |
| Was this pregnancy unplanned? | | | |
| Are you unhappy about being pregnant? | | | |
| Have you had any problems so far with this pregnancy? | | | |
| Have you seen a doctor or had any ultrasound done during this pregnancy so far? | | | |
| How much did you weigh before becoming pregnant? | | | |
| What was the first day of your last menstrual period? | | | |
| Was your last menstrual period abnormal in duration or flow? | | | |
| Are you uncertain of the date of your last menstrual period? | | | |
| Had you been on birth control pills or injections during the last 3 months before becoming pregnant? | | | |
| Has anyone in your family had hypertension or preeclampsia (Toxemia) during pregnancy? | | | |