Harvard Family Physicians, P.C.
OB / GYN

Medical Questionnaire

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Date:_____

NAME:_____ DOB:_____ AGE:_____ SEX: _____

MARITAL STATUS:_____ # OF CHILDREN:_____ OCCUPATION:_____

PRIMARY CARE PHYSICIAN:_____PREFERRED PHARMACY LOCATION:_____

Past Medical History: (check any of the following which you have or been treated for)

❒ High Blood Pressure ❒ Heart Disease ❒ Diabetes ❒ Cancer
❒ Liver Disease ❒ Kidney Disease ❒ Asthma/Emphysema ❒ Stomach Trouble
❒ Neurologic Disease (Stroke, etc) ❒ Arthritis ❒ Cholesterol
❒New Disease or Disorder ❒ Other_____

Surgical Procedures	Year and Where	Hospitalizations	Year and Where

Current Medications: (including dosage and frequency; include prescription, over-the-counter, vitamins, birth control pills, etc.)

_____ _____
_____ _____
_____ _____

ALLERGIES TO MEDICATIONS			
OTHER ALLERGIES			

Family History: (check all that apply)	Relation	Age it Occurred
❒ Hypertension		
❒ Heart attack, strokes (circle one)		
❒ Diabetes		
❒ Ovarian Cancer		
❒ Breast Cancer		
❒ Colon Cancer		
❒ Tuberculosis		
❒ Glaucoma		
❒ Nervous Disorder		

Social History:

Cigarettes:_____packs/day for _____years. Quit?_____
Alcoholic drinks:_____drinks per_____week_____Month. Quit?_____
Coffee:_____cups/day; pop/tea:_____glasses/day
Exercise type:_____day/week_____
Hobbies:_____

Birth:	**Name of Children**	**Age**
Any new pregnancies?_____		
How many pregnancies?_____		
# of miscarriages_____		
# of c/sections_____		
# of vaginal_____		

GYN:

Any history of sexual or physical abuse? If so, when?_____
Would you like information or help?_____
Sexually active? Yes/No_____Do you have sex with men, women or both?_____
In the past year, have you had any changes in sexual partners? Yes/No_____History of STD's Yes/No_____
Last menstrual period_____Regular/Irregular_____Normal? Yes/No_____
# of days on menstrual cycle_____Last pap_____Ever had abnormal pap smear? Yes/No
Method of birth control_____Last mammogram date_____
Last bone density test_____Last colonoscopy_____

(continued on back)

Systems Review: (check if you have or have had any of the following)

GENERAL

_____ recent weight loss/gain (circle one)

_____ fevers or nights sweats

_____ mood disturbance (depression, anxiety, etc.)

HEAD/NEUROLOGIC

_____ headache

_____ dizziness

_____ paralysis or weakness of arms or legs

_____ numbness

_____ tremor or shakes

ENT

_____ double vision

_____ dark spots or flashing lights before your eyes

_____ recent change in vision

_____ hearing loss

_____ nose bleed

_____ sores in mouth

_____ frequent sore throats

_____ hoarseness or voice change

NECK

_____ fullness in the neck or throat

HEART and LUNGS

_____ shortness of breath

_____ asthma or wheezing

_____ cough

_____ irregular or rapid heart beat

_____ swelling (edema)

_____ murmurs

SKIN/HAIR

_____ sores

_____ skin cancers

_____ hair loss

_____ itching

STOMACH and BOWELS

_____ Abdominal pain

_____ nausea

_____ vomiting

_____ constipation

_____ diarrhea

_____ bloody or black stools (circle one)

GENITOURINARY

_____ increased frequency of urination

_____ urinary urgency

_____ getting up at night to urinate - # of time _____

_____ history of urinary infections

_____ blood in the urine

_____ difficulty urinating or burning or urination

_____ leakage or dribbling of urine

_____ history of venereal disease

_____ lumps in genital area

_____ kidney stones

_____ sexual difficulties

MENSTRUAL

_____ vaginal discharge

_____ vaginal or pelvic discomfort (circle one)

_____ pain during intercourse

_____ bleeding after intercourse

MUSCLES, BONES, and JOINTS

_____ joint pain or stiffness

_____

Patient Signature **Date**

_____

Physician Signature **Date**