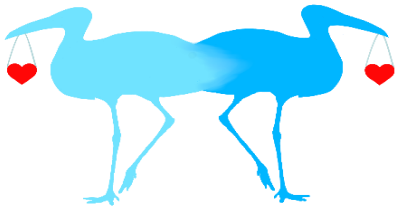
Scottsdale  OBGYN

Personal

How old are you: _____ How did you hear about us? _____

Pharmacy name & cross streets or address: _____

Referring doctor's full name & phone number: _____

PATIENT MEDICAL QUESTIONNARE

Please list the MAIN reason for today's office visit and how long you have had it:

_____

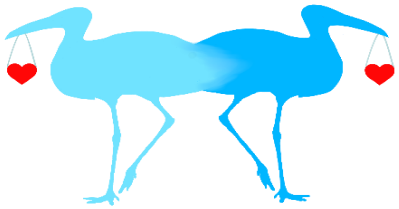
Please list the name of all your Medications: (including birth control, hormones or herbals)

Name of medication	Strength (mg)	Form (tablet, cream etc.)	How many times a day?

Allergies: Please list all your allergies incl. reaction (rash, throat swelling, anaphylaxis etc.):

_____

First name: _____ Last name: _____

Scottsdale  OBGYN

Personal

MEDICAL HISTORY: Please circle or list any existing medical condition & since what year:

Heart disease __	**Lung disease/Asthma __**	**High blood pressure __**	**Diabetes __**	**Cancer __**
Bleeding disorder __	**blood clots legs/lungs __**	**Seizure disorder __**	**Thyroid disease __**	**Fibroid __**

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL HISTORY: Please circle or list any surgeries or any hospital admissions and the year:

Hysterectomy (abdominal, vaginal, Laparoscopy) __	**Removal of ovary (Lt/Rt) __**	**Removal of fibroids __**
Colposcopy of cervix for abnormal pap __	**LEEP, laser, freeze cervix __**	**D&C __**
Bladder/Vaginal Prolapse __	**Urinary incontinence __**	**Endometriosis surgery __**
Hysteroscopy uterine polyp __	**Endometrial ablation __**	**Ovarian cyst surgery (Lt/Rt) __**

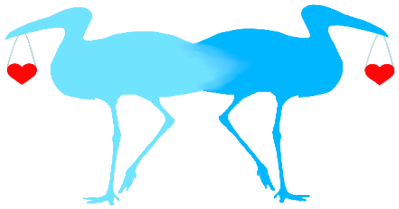
Year	Name of the procedure or Reason for hospitalization	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OBSTETRICAL HISTORY: Please list all your pregnancies:

Total number of pregnancies: ___	**# of deliveries at 37 wks or more: ___**	**# of deliveries at 36 wks or less: ___**
Number of miscarriages: ___	**Number of abortions: ___**	**Number of ectopics: ___**
Number of living children: ___		

Name	Yr/Mo	How far (weeks)	Vaginal or C-section	Complications	Birth Wt.	Boy/Girl
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

First name: _____ Last name: _____

Scottsdale  OBGYN

Personal

GYNECOLOGICAL HISTORY

Menstrual Periods:

Last Menstrual Period: _____

Age when started: _____ years old

Length of cycles? (e.g. 28 days) _____ days

Length of periods? (4-5 days) _____ days

Pap Smear:

Date of last Pap: _____

Was it normal: __ Yes __ No

Where was it done? _____

Mammogram:

Date of last Mammo: _____

Was it normal: __ Yes __ No

Where was it done? _____

Birth Control:

Current method: _____

Previous methods: _____

Which of the following apply to you now:

(mark with **X and the Year/Month started**)

Unusually painful periods __

Bleeding between periods __

Bleeding with intercourse __

Irregular periods __

Pain with sex on insertion __

Pain with sex on deep penetration __

Previous abnormal pap __

Feeling that pelvic organs falling out __

Involuntary loss of urine __

Previous gonorrhea, chlamydia, herpes __

History of other STD or PID __

Sexual problem in current relationship __

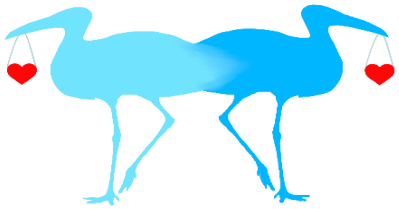
History of sexual assault __

Last colonoscopy __ Abnormal __

Last bone density scan __ Abnormal __

Last cholesterol test __ Abnormal __

First name: _____ Last name: _____

Scottsdale  OBGYN

Personal

Within the last 30 days have you had any of the following problems?* (please circle if applies):

General: Fever, chills, significant weight loss or gain (___ lbs. over the last ___ months)

Cardiovascular: chest pain, heart racing, shortness of breast walking up 1 flight of stairs

Pulmonary: cough, bloody sputum, shortness of breath at rest, wheezing

GI: abdominal pain, nausea/vomiting, diarrhea, constipation, bloody stools, bowel habit changes

Urinary: burning with urination, urinary frequency, urgency, blood in urine

Neurological: Migraine headaches with aura, paralysis, numbness/tingling, seizure

Endocrine: feeling hot/cold all the time, hot flashes, night sweats, excessive thirst

Skin: Rash, skin ulceration, itching, skin disease, autoimmune disease

Psychiatric: depression, anxiety

Hematologic: anemia, easy brusing, weekly nose bleed, blood transfusion (ever)

Other: breast pain, breast lump, discharge or milk from the nipples

**If you are experiencing any of these symptoms please contact your primary care doctor*

Family History

List any **close relatives** that applies (who & age of onset)

High Blood Pressure: _____

Diabetes: _____

Breast Cancer: _____

Ovarian/Colon/Uterine Cancer: _____

Other conditions/illnesses: _____

Social History

Exercise Yes __ x ___ /week

Smoking Yes __ x ___ pack/day

Alcohol Yes __ x ___ drink/week

Illicit Drugs Yes __ Type ____

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