North Shore OB GYN Associates
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Suite 301
Great Neck, NY 11021
(516) 472-5700

Medical History Questionnaire

The following medical questionnaire helps us to gather information from you. It's only preliminary. You will be questioned in greater detail concerning your present complaints and concerns when you see the doctor. If any parts of this form are confusing or unclear you may leave them blank and the doctor will explain them when you are seen.

Date: _____
Name: _____
Address: _____
Telephone: Home _____
Work _____
Date of Birth _____
Social Security Number: _____
Marital Status (Please Circle): Married Single Divorced Separated Widowed
Race (Please Circle): White African American Hispanic Asian Native American Other
Mother's Name: _____
Father's Name: _____
Referring Physician _____

Obstetrical & Gynecology History

When was the first day of your last period? _____
Age of first menstrual cycle? _____Age of Menopause _____
How often do you get your period? _____
How often does your average period last? _____
Are your periods excessively painful or heavy? _____
Are you sexually active?(Please Circle) Yes No
What contraceptive method do you use? _____
How many times have you been pregnant? _____
How many children do you have? Please list dates and types of deliveries
_____

Have you ever been treated for any of the following? (Please Circle One)

Sexually Transmitted Diseases	YES	NO
Abnormal Pap Smears	YES	NO
Infertility	YES	NO
Fibroids	YES	NO
Ovarian Cyst	YES	NO
Endometriosis	YES	NO

Other Gynecological problems? _____
When was your last mammogram? _____
When was your last pap? _____When was your last bone density? _____
When was your last colonscopy? _____

Medical History

Please circle Yes or No. For any Yes responses, please provide details in the space provided.

Heart Disease (Murmur, angina, heart attack) YES NO _____
Lung Disease (Asthma, Pneumonia, TB) YES NO _____
High Blood Pressure YES NO _____
Diabetes YES NO _____
Liver Disease (Hepatitis) YES NO _____
Gastrointestinal Disease YES NO _____
Thyroid Problems YES NO _____
Blood Related Disease YES NO _____
Kidney Disease YES NO _____
Cholesterol Problems YES NO _____
Joint Disease YES NO _____
Neurological Disease YES NO _____
Psychiatric Illness YES NO _____
Other Serious Illnesses YES NO _____

Have you ever had surgery? (Please List Operations and Dates) YES NO _____
_____

Any other hospitalizations? YES NO _____
Any blood transfusions? YES NO _____
Any allergies to latex or medication? YES NO _____

Has anyone in your family had? (Please Indicate Which Family Member And What Type)

Diabetes YES NO _____
Heart Disease (Murmur, heart attack) YES NO _____
Cancer (What Type?)

FTH_____ MTH_____ PGM_____ PGF_____

MGM_____ MGP_____ BROTHER_____ SISTER_____
MAUNTS_____ MUNCLES_____ PAUNTS_____ PUNCLE_____

Inherited Genetic Disease?

FTH_____ MTH_____ PGM_____ PGF_____

MGM_____ MGP_____ BROTHER_____ SISTER_____
MAUNTS_____ MUNCLES_____ PAUNTS_____ PUNCLE_____

What medications do you currently use? (Please list dosage) _____
_____

Do you currently use or have you ever used?

Tobacco? YES NO Duration Of Use? _____Currently Use? YES NO
Alcohol? YES NO Duration Of Use? _____Currently Use? YES NO
Street Drugs? YES NO Duration Of Use? _____Currently Use? YES NO

Are you presently experiencing any of the following? (Circle all that apply)

Abnormal Vaginal Bleeding Pelvic Pain Breast Pain-Discharge Jaundice

Vaginal Discharge or Irritation Urinary Problems Incontinence

Chest Pain Frequent Headaches Chronic Cough Numbness Visual Changes

Abdominal Pain Changes in bowel movement Fainting Abnormal Bleeding