

# MOGA

## PATIENT MEDICAL QUESTIONNAIRE

Date \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Husband Name: \_\_\_\_\_ Age: \_\_\_\_\_

Single     Married     Divorced     Separated

Occupation: \_\_\_\_\_

Occupation \_\_\_\_\_

Employer: \_\_\_\_\_

Preferred Title (Catherine, Cathy, Mrs. Jones): \_\_\_\_\_

Who to notify in case of emergency: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Telephone: \_\_\_\_\_

**Main reason for office visit today**

**Ethnicity**     Black     Caucasian     Hispanic     Native American     Other

**Specific problem**

**Duration**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OBSTETRICAL HISTORY**

List ALL pregnancies (including miscarriages, abortions, etc.)

Year	Length of Pregnancy	Facility or Hospital	Complications	Birth wt.	Sex	Name
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____

**GYNECOLOGICAL HISTORY**

**Menstrual Periods**

Date of last period \_\_\_\_\_

age when you started \_\_\_\_\_

how long do you flow \_\_\_\_\_

**Pap Smear**

date of last one \_\_\_\_\_

where was this done \_\_\_\_\_

**Birth Control**

current method \_\_\_\_\_

previous methods used \_\_\_\_\_

\_\_\_\_\_

**Which of the following apply to you:**

- \_\_\_\_\_ unusually painful periods
- \_\_\_\_\_ bleeding between periods
- \_\_\_\_\_ irregular periods
- \_\_\_\_\_ previously abnormal pap smear
- \_\_\_\_\_ pain with intercourse
- \_\_\_\_\_ feeling that pelvic organs are falling out
- \_\_\_\_\_ involuntary loss of urine
- \_\_\_\_\_ previous pelvic infection (not vaginal)
- \_\_\_\_\_ previous venereal disease
- \_\_\_\_\_ sexual or marital problems

PAST MEDICAL HISTORY

Existing medical disorders \_\_\_\_\_

Previous surgery (including d&c, tonsils, etc.)

Year	Surgery	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous hospitalizations, other than surgery

Year	Problem	Hospital
_____	_____	_____
_____	_____	_____

Medications

a) Medicines you take:  
(including birth control)

b) Medicines you are allergic to:

Have you ever had any of the following problems?

Cardiovascular

- Heart trouble Yes \_\_\_\_\_
- Heart murmurs Yes \_\_\_\_\_
- Rheumatic fever Yes \_\_\_\_\_
- Blood clots (legs or lungs) Yes \_\_\_\_\_
- High blood pressure Yes \_\_\_\_\_
- Anemia Yes \_\_\_\_\_
- Blood transfusions Yes \_\_\_\_\_

Urinary

- Kidney infection Yes \_\_\_\_\_
- Bladder infection Yes \_\_\_\_\_
- Blood in urine Yes \_\_\_\_\_

Neurological

- Frequent headaches Yes \_\_\_\_\_
- Fainting spells Yes \_\_\_\_\_
- Convulsions Yes \_\_\_\_\_

Pulmonary

- Chest Pains Yes \_\_\_\_\_
- Pneumonia Yes \_\_\_\_\_
- TB or Valley Fever Yes \_\_\_\_\_
- Other chest pains Yes \_\_\_\_\_
- Do you smoke? Yes \_\_\_\_\_

Endocrine

- Thyroid problems Yes \_\_\_\_\_
- Diabetes Yes \_\_\_\_\_
- Recent weight change Yes \_\_\_\_\_

Gastrointestinal

- Gall bladder problems Yes \_\_\_\_\_
- Yellow jaundice (hepatitis) Yes \_\_\_\_\_
- Ulcers Yes \_\_\_\_\_
- Bloody stools or vomitus Yes \_\_\_\_\_
- Bowel habit changes Yes \_\_\_\_\_
- Colitis or spastic colon Yes \_\_\_\_\_

Other

- Breast problems Yes \_\_\_\_\_
- Cancer Yes \_\_\_\_\_
- Depression Yes \_\_\_\_\_
- Psychiatric care Yes \_\_\_\_\_
- Bone problems Yes \_\_\_\_\_
- Muscle problems Yes \_\_\_\_\_
- History of Alcohol or Drug Abuse Yes \_\_\_\_\_

Family History

Any close relatives with:

Who:

- high blood pressure Yes \_\_\_\_\_
- diabetes Yes \_\_\_\_\_
- breast cancer Yes \_\_\_\_\_
- other cancer Yes \_\_\_\_\_
- other conditions/illnesses Yes \_\_\_\_\_