

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 _____