Better Women's Care
Medical Questionnaire

Name: _____ Date of Birth: _____ Age: _____

Reason for Visit

What brings you to the office today?

_____
_____
_____
_____
_____

Date of Appointment:

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

_____
_____

Current Medications

What medications are you currently taking?

_____
Name Dosage Frequency

_____
Name Dosage Frequency

_____
Name Dosage Frequency

_____
Name Dosage Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

_____
_____

Past Medical History

□ Allergies	□ Cancer	□ Heart Disease	□ Liver Disorder	□ Stroke
□ Anemia	□ Crohn's Disease	□ Heart Problems	□ Lung Disease	□ Thyroid Disease
□ Anxiety Disorder	□ Diabetes	□ Hepatitis A, B, or C	□ Migraines	□ Tuberculosis
□ Arthritis	□ Depression	□ High Blood Pressure	□ Osteoporosis	□ Venereal Disease
□ Asthma	□ DVT	□ High Cholesterol	□ Phlebitis	□ Seizure
□ AIDS /HIV	□ GERD	□ IBS	□ Skin Disorder	□ Sickle Cell
□ Bleeding Disorder	□ Glaucoma	□ Kidney Disorder	□ Stomach Ulcer	□ Other: _____
□ Blood Transfusion				

Hospitalizations & Surgeries

_____
Reason Date

_____
Reason Date

_____
Reason Date

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year: _____

Do you wish to be checked for STD's?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally abused you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years: _____ # of packs/day: _____

Do you smoke now? ☐ Yes ☐ No # of packs/day: _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism	☐ Cancer	☐ Joint Disease
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disease
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS / HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ High Blood Pressure	☐ Thyroid Disorder

Details: _____
_____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week: _____

How much alcohol do you drink per week?

drinks per week: _____

How much caffeine do you drink per day?

drinks – coffee:_____ tea: _____ pop: _____

How often do you exercise?

times/week: _____

Better Women's Care
Medial Questionnaire

Name: _____ Date of Birth: _____ Age: _____

OB-GYN History

Date:

Have you ever had or do you currently have any of the following?

□ Abnormal Vaginal Bleeding	□ Breast Surgery	□ Endometriosis	□ Herpes	□ Nipple Discharge	□ Trichomonas
□ Abnormal Pap Smear	□ Cervical Cancer	□ Extreme menstrual pain	□ Hot Flashes	□ Ovarian Cysts	□ Uterine Cancer
□ Bleeding between Periods	□ Chlamydia	□ Fibroids	□ HPV	□ Ovarian Cancer	□ Urinary Incontinence
□ Breast Lump	□ Colposcopy	□ Genital Warts	□ Infertility	□ Painful Intercourse	□ Yeast Infections -Frequent
□ Breast Cancer	□ Cryosurgery	□ Gonorrhea	□ Irregular Periods	□ Pelvic Inflammatory Disease	

Pregnancy History

Please describe any pregnancies you have had.

_____ _____ _____ _____ _____
# of pregnancies # full term # pre-term # of Miscarriages # of Abortions

Past Pregnancies

Date Length of Pregnancy Type of Delivery Weight Sex

_____

_____

_____

_____

_____

Were there any complications associated with any of your pregnancies?

_____
_____
_____
_____

Are you currently Pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Do you plan on having children in the next
1-5 years? _____ 10 years? _____ family is complete? _____

Do you need birth control or contraceptive advice? ☐ Yes ☐ No

What method of birth control do you use?

_____

Are you interested in learning about a non-hormonal, non-surgical permanent birth control option performed in the comfort of our office?

☐ Yes ☐ No

Routine History

Last Pap Smear: Date: _____ Location: _____

Last Mammogram: Date: _____ Location: _____

Last Colonoscopy: Date: _____ Location: _____

Last Bone Density: Date: _____ Location: _____

Menstrual History

When was the first day of your last period?

_____

How often does your period occur?

_____

How long does your period last?

_____

Is your period regular? ☐ Yes ☐ No

Are your periods heavy? ☐ Yes ☐ No

Do your periods affect your daily activities? ☐ Yes ☐ No

What age were you when you had your first period? _____

What age were you at menopause? _____

Urinary Health

Do you experience leaking while laughing, sneezing, jumping or performing other movements that put pressure on the bladder?

☐ Yes ☐ No

Do you frequently experience a sudden and immediate urge to urinate?

☐ Yes ☐ No

Have you noticed a change in your frequency of urination or burning?

☐ Yes ☐ No

Would you like information on a minimally invasive incontinence procedure?

☐ Yes ☐ No

Prolapse

Have you ever felt a bulge or lump in your vagina? ☐ Yes ☐ No

Do you feel like something is falling out of your vagina? ☐ Yes ☐ No

Do you experience pain or discomfort during intercourse? ☐ Yes ☐ No

Do you experience vaginal pain, pressure, irritation, bleeding or spotting?

☐ Yes ☐ No