MEXICO WOMENS HEALTH SPECIALISTS
Carla Price, FNP-BC
Medical History Questionnaire

Patient Name _____ Age _____ Date: _____

Reason for Visit _____

Allergies to medication/latex:

Medication _____ Reaction _____

_____ _____

Recent test results:

	Date	Result
Pap Smear/HPV	_____	_____
Mammogram	_____	_____
Colonoscopy	_____	_____
FOBT	_____	_____
Bone Density	_____	_____

Have you received the Gardasil Vaccine? Yes ___ No ___

Periods

First Day of Last Period _____ Age at first period _____

Frequency of Periods _____ Irregular Periods Yes ___ No ___

Menstrual Cramps: Severe ___ Moderate ___ Light ___ None ___

Menstrual Flow: Heavy ___ Moderate ___ Light ___

How many pads/tampons per day _____

Gyn Surgery

Hysterectomy Yes ___ No ___ Reason for hysterectomy _____

Ovaries removed? Yes ___ No ___ If yes, both ___ right ___ left ___

Ablation Yes ___ No ___ Date _____ D&C Yes ___ No ___ Date _____

General Surgery:
Please mark all that apply

Tonsillectomy ___ Appendectomy ___ Mastectomy ___ Gallbladder ___ Cardiac Bypass ___

Other Surgeries _____
Obstetrical History:

Number of Pregnancies _____ Number of Deliveries _____ Premature deliveries _____

Contraception

Current form of contraception:

None ___ Pill ___ Depo Provera ___ Condoms ___ Tubal Ligation ___ IUD ___

Vasectomy ___ Withdrawal ___ Rhythm ___ Nexplanon (implant) ___

Medical Problems
Please mark all that apply

Cancer ___ Type: _____

High Blood Pressure _____ Migraines ___ Blood Clots ___ Liver disease ___

Diabetes ___ Depression ___ Anemia ___ Seizure disorder ___ Thyroid disease ___

Varicose veins ___ Rheumatic fever ___ Heart attack ___ Angioplasty ___

Coronary Artery Disease ___ Other serious illness _____

Other Hospitalizations _____

Has anyone in your family been diagnosed with the following types of cancer?

Breast Yes ___ No ___ If yes, who? _____

Ovarian Yes ___ No ___ If yes, who? _____

Uterus Yes ___ No ___ If yes, who? _____

Colon Yes ___ No ___ If yes, who? _____

Has anyone in your family been treated for the following conditions?
If yes, please write the relationship

High Blood Pressure _____ Diabetes _____ Stroke _____

Heart Attack (Age) _____ Heart Disease _____

Please list any new medications since your previous visit, also include reason for the medication

_____ _____

_____ _____

Do you smoke? Yes ___ No ___ If yes: Packs per day _____ Years smoked _____
Marijuana Use? Yes ___ No ___
Alcohol Use: None ___ Drinks per week _____

Were you referred by another health care provider? Yes ___ No ____
If yes, who? _____

Patient Signature
_____ **Date:** _____

Provider Signature
_____ **Date:** _____