FAMILY HISTORY – **Michael D. Jones, M.D. F.A.C.O.G. - Carla Price, FNP**
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HAS ANYONE IN YOUR IMMEDIATE FAMILY EVER BEEN TREATED FOR ANY OF THE FOLLOWING?
(GRANDPARENTS, PARENTS, SIBLINGS)

DIABETES_____ HYPERTENSION (High Blood Pressure)_____

STROKE_____ CORONARY ARTERY DISEASE (HEART ATTACK, BYPASS SURGERY, ANGIOPLASTY)_____

HAVE YOU EVER HAD SURGERY? YES_____ NO_____

PLEASE LIST SURGERY AND LIST THE YEAR OF SURGERY

TONSILLECTOMY_____ APPENDECTOMY_____

D&C_____ GALLBLADDER_____

MASTECTOMY_____ HYSTERECTOMY_____

WERE YOUR OVARIES REMOVED? BOTH_____ RIGHT_____ LEFT_____

ANY OTHER SURGERY?_____

ANY OTHER HOSPITALIZATIONS? _____

ARE YOU TAKING ANY MEDICATION? PLEASE LIST MEDICATIONS AND DOSAGE.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? YES_____ NO_____

PLEAE LIST MEDICATION AND TYPE OF REACTION

MEDICATION_____ **REACTION**_____

_____ _____

_____ _____

DO YOU SMOKE? YES_____ NO_____ HOW MANY PACKS PER DAY_____
DO YOU DRINK? YES_____ NO_____ HOW MANY PER DAY_____ WEEK_____

DO YOU HAVE ANY PROBLEMS WITH BLADDER CONTROL? YES_____ NO_____

IF YOU HAVE ANY PROBLEMS WITH LEAKING URINE WHEN COUGHING, EXERCISING, ETC., PLEASE MENTION THIS TO THE NURSE BEFORE YOU USE THE RESTROOM.

WERE YOU REFERRED BY ANOTHER DOCTOR? DR._____
PRIMARY DR_____

DO NOT WRITE BELOW THIS LINE

WEIGHT_____ BP_____ LMP_____ G_____ P_____ AB_____

TETANUS_____ FLU VACCINE_____ PNEUMONIA VACCINE_____ TSH_____

MEDICAL HISTORY QUESTIONNAIRE: **Michael D. Jones, M.D.,F.A.C.O.G. - Carla Price, FNP**
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ALL INFORMATION IS STRICTLY CONFIDENTIAL. IF THERE IS ANY INFORMATION YOU WOULD PREFER TO DISCUSS WITH THE NURSE OR DOCTOR DIRECTLY, PLEASE FEEL FREE TO DO SO.

NAME_____AGE_____DATE_____

REASON FOR VISIT_____

DATE OF LAST PAP SMEAR_____WHERE_____

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?_____

DATE OF LAST MAMMOGRAM_____WHERE_____

FIRST DAY OF YOUR LAST MENSTRUAL PERIOD_____AGE AT FIRST PERIOD_____

HOW FREQUENT ARE YOUR PERIODS?_____IRREGULAR_____

DO YOU CONSIDER YOUR PERIODS HEAVY_____NORMAL_____LIGHT_____

HOW MAY PADS/TAMPONS PER DAY?_____

DO YOU HAVE MENSTRUAL CRAMPS? SEVERE_____MODERATE_____MILD_____

DO YOU HAVE PAIN WITH INTERCOURSE? YES_____NO_____

CONTRACEPTIVE CURRENTLY USED – FOR SEXUALLY ACTIVE PATIENTS

PILL_____IUD_____DEPOPROVERA_____CONDOMS_____

FOAM_____WITHDRAWAL_____RHYTHM_____TUBAL LIGATION_____

VASECTOMY_____NONE_____

TOTAL PREGNANCIES_____ANY PREMATURE DELIVERIES_____

MISCARRIAGES_____ANY COMPLICATIONS_____

HAVE YOU EVER BEEN TREATED FOR:

RHEUMATIC FEVER_____EPILEPSY_____BLOOD CLOT IN LEGS/LUNGS_____

DIABETES_____DEPRESSION_____ASTHMA_____ANEMIA_____

VARICOSE VEINS_____HYPERTENSION (High Blood Pressure)_____MIGRAINE HEADACHE_____
(NOT SPIDER VEINS)

LIVER DISEASE_____KIDNEY DISEASE_____THYROID CONDITION_____

CORONARY ARTERY DISEASE_____(HEART ATTACK, BYPASS, ANGIOPLASTY)

ANY OTHER SERIOUS ILLNESS_____

HAS ANYONE IN YOUR FAMILY EVER BEEN TREATED FOR CANCER OF THE:

BREAST_____OVARIES_____

UTERUS_____COLON_____