

**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 \_\_\_\_\_ (High Blood Pressure) HYPERTENSION \_\_\_\_\_

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 \_\_\_\_\_

**PLEASE 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 MANY 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 \_\_\_\_\_ MIGRAINE HEADACHE \_\_\_\_\_  
(NOT SPIDER VEINS) (High Blood Pressure)

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 \_\_\_\_\_