North Shore OB GYN Associates
600 Northern Blvd, Ste. 212
Great Neck, NY 11021
(516) 472-5700

Medical History Questionnaire

The following medical questionnaire helps us gather preliminary information about you. You will be asked more detailed questions concerning your present complaints and concerns when you see the doctor. If any part of this form is confusing or unclear you may leave it blank and the doctor will explain them when you are seen.

Date: _____
Name: _____
Address: _____
Tel.: Primary (home/cell) _____ Secondary (home/cell) _____
Date of Birth_____ **Social Security Number:** _____
Marital Status (Please Circle): Married Single Divorced Separated Widowed
Race (Please Circle): White, African American, Hispanic, Asian, Native American, Other
Mother's Name: _____
Father's Name: _____
Referring Physician _____

Obstetrical & Gynecology History
When was the first day of your last period _____
Age of first menstrual cycle ____ Age of Menopause _____
How often do you get your period _____
How often does your average period last? _____
Are your periods excessively painful or heavy? _____
Are you sexually active?(Please Circle) Yes No
What contraceptive method do you use? _____
How many times have you been pregnant? _____
How many children do you have? ____
Please list dates and types of deliveries (vaginal/c-section)
_____

Have you ever been treated for any of the following?
(Please Circle YES or NO on every line)

Sexually Transmitted Diseases	YES	NO
Abnormal Pap Smears	YES	NO
Infertility	YES	NO
Fibroids	YES	NO
Ovarian Cyst	YES	NO
Endometriosis	YES	NO

Other Gynecological problems? _____
When was your last mammogram? _____ When was your last pap? _____
When was your last bone density? _____ When was your last colonoscopy? _____

Medical History

Please circle Yes or No. For any Yes responses please provide details in the space provided.

Heart Disease (Murmur, angina, heart attack) YES NO _____
Lung Disease (Asthma, Pneumonia, TB) YES NO _____
High Blood Pressure YES NO _____
Diabetes YES NO _____
Liver Disease (Hepatitis) YES NO _____
Gastrointestinal Disease YES NO _____
Thyroid Problems YES NO _____
Blood Related Disease YES NO _____
Kidney Disease YES NO _____
Cholesterol Problems YES NO _____
Joint Disease YES NO _____
Neurological Disease YES NO _____
Psychiatric Illness YES NO _____
Other Serious Illnesses YES NO _____

Have you ever had surgery? (Please List Operations and Dates) YES NO

_____

Any other hospitalizations? YES NO
If yes: when/ why _____
Any blood transfusions? YES NO
If yes: when/ why _____
Any allergies to latex or medication? YES NO _____

Has anyone in your family had? (Please Indicate Which Family Member & What Type)

Diabetes YES NO _____
Heart Disease (Murmur, heart attack) YES NO _____
Cancer (What Type?)

FTH_____ MTH_____ PGM_____ PGF_____

MGM_____ MGP_____ BROTHER_____ SISTER_____
MAUNTS_____ MUNCLES_____ PAUNTS_____ PUNCLE_____

Inherited Genetic Disease?

FTH_____ MTH_____ PGM_____ PGF_____

MGM_____ MGP_____ BROTHER_____
SISTER_____ MAUNTS_____ MUNCLES_____
PAUNTS_____ PUNCLE_____

What medications do you currently use? (List Name Dose, Route Frequency)

_____

Do you currently use or have you ever used?

Tobacco? YES NO Duration Of Use? _____Currently Use? YES NO
Alcohol? YES NO Duration Of Use? _____Currently Use? YES NO
Street Drugs? YES NO Duration Of Use? _____Currently Use? YES NO

Are you presently experiencing any of the following? (Circle all that apply)

Abnormal Vaginal Bleeding / Pelvic Pain / Breast Pain-Discharge / Jaundice / Cough / Vaginal Discharge or Irritation / Urinary Problems / Incontinence / Chest Pain / Frequent Headaches / Chronic / Numbness / Visual Changes / Abdominal Pain / Changes in bowel movement / Fainting / Abnormal Bleeding