Her Choice Midwifery Services

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Normal, IL 61761

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PATIENT HISTORY QUESTIONNAIRE

1. Martial Status: [ ] Single [ ] Married [ ] Long term Relationship [ ] Divorced [ ] Widowed

2. Reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Referring Provider or How found Her Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Preferred Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Partner#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

last first

7. Age of Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8: Occupation of Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)**

9. Age at first period: \_\_\_\_\_\_\_ years.

10. If your menstrual periods are regular; periods start every: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ days

11. If your menstrual periods are irregular; periods start ever: \_\_\_\_\_\_ to \_\_\_\_\_\_ to days

12. Duration of bleeding: \_\_\_\_ days

13. Does bleeding or spotting occur between periods? [ ] Yes [ ] No

14. Does bleeding or spotting occur after intercourse? [ ] Yes [ ] No

15. First day of last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

month day year

16. Is pain associated with periods? [ ] Yes [ ] No [ ] Occasionally

17. If yes to 14, is it: before menses? [ ] during menses? [ ] [ ] both?

**Pregnancy History**

18. Ever been pregnant? [ ] Yes [ ] No

19. Obstetrical History Including Abortions & Ectopic (Tubal) Pregnancies

CHILD

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Month/Year | Place of Delivery(home  Hospital/state) | Weeks at  Delivery | Hrs. of Labor | Vaginal/CS/  VBAC | Complications of mother and/or infant. | Sex | Birth  Weight | Present Health |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

**Birth Control History**

20. What birth control method(s) do you currently use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual History**

21. Do you have a sexual partner? [ ] Yes [ ] No (Male [ ] Female [ ])

22. Are there concerns about your sexual activity which you may want to discuss with your doctor? [ ] Yes [ ] No

**Past Obstetrical/Gynecological Surgeries**

23. Check any that apply: or none [ ]

**Surgery Year**

[ ] D/C [ ]

[ ] Hysteroscopy [ ]

[ ] Infertility Surgery [ ]

[ ] Tuboplasty [ ]

[ ] Tubal Ligation [ ]

[ ] Laparoscopy [ ]

[ ] Hysterectomy (Vaginal) [ ]

[ ] Hysterectomy (Abdominal) [ ]

[ ] Myomectomy [ ]

[ ] Ovarian Surgery [ ]

[ ] L Cyst(s) removed ovarian [ ]

[ ] R Cyst(s) removed ovarian [ ]

[ ] L Ovary Removed [ ]

[ ] R Ovary Removed [ ]

[ ] Vaginal or bladder repair

for prolapsed or incontinence [ ]

[ ] Cesarean section [ ]

[ ] Other (specify) [ ]

**Past Surgical History (Not OB/GYN)**

24. List all surgeries and their year or [ ] None Year

Surgeries

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pap Smear/Mammogram History**

25. [ ] Date of last pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

26. [ ] Have you had abnormal pap smears? [ ] No [ ] Yes Cryotherapy

27. [ ] Have you had treatment for abnormal smears? [ ] No [ ] Yes Laser

Cone Biopsy

If yes, what type(s) of treatment have you had? Loop Excision

28. Date of last mammogram: \_\_\_\_\_\_ \_\_\_\_\_\_\_

month year

29. Have you ever had an abnormal mammogram? [ ] No [ ] Yes

**OTHER**

30. Check any that apply: [ ]None [ ]Venereal Warts [ ]Herpes-genital [ ]Syphilis

[ ]Pelvic inflammatory disease [ ]Endometriosis [ ]Chlamydia [ ]Gonorrhea

[ ] Vaginal infections [ ]Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please specify which family member has the following listed medical conditions

M: Mother, F: Father, B: Brother, S: Sister, MGM: Maternal Grandmother, MGF: Maternal Grandfather, PGM: Paternal Grandfather, PGF: Paternal Grandfather

[ ] Gynecological Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Breast Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Diabetes: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Heart Attack before 50: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Any other hereditary diseases: \_\_\_\_\_\_\_\_\_\_\_\_

**YOUR MEDICAL HISTORY** Check any that apply: or [ ] None

[ ] Arthritis [ ]Kidney Disease [ ] Asthma

[ ] Diabetes: [ ]Gallstones [ ]Emphysema

[ ]Diet controlled [ ]Liver Disease [ ]Bronchitis

[ ]Pill controlled (including hepatitis) [ ]HIV+

[ ]Insulin controlled [ ]Epilepsy [ ]Eating Disorder

[ ]High blood pressure [ ]Blood Transfusions [ ]Other: \_\_\_\_\_\_\_\_

[ ]Heart disease [ ]Thyroid disease

**CURRENT MEDICATIONS (Include dose (amount) per day)**

Medication Dose Frequency

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**DRUG ALLERGIES**

[ ]No [ ]Yes: List and reactions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DO YOU CURRENTLY?**

31. Smoke [ ]No [ ]Yes\_\_\_\_\_\_ packs/day

32. Use alcohol [ ]No [ ]Yes: how much per week: \_\_\_\_\_\_\_\_\_, Caffeine [ } N [ ] Y: how much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

33. Use illicit drugs [ ]No [ ]Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_ type \_\_\_\_\_\_\_\_\_\_\_\_\_ amount

34. Exercise [ ]No [ ]Yes Type: \_\_\_\_\_\_\_\_\_\_\_ How often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Symptoms**

Have you had recent?

[ ]weight loss [ ]hair growth [ ]none of the above

[ ]weight gain [ ] hair loss [ ]none of the above

[ ]change in energy [ ]change in urinary function [ ]Other: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]change in exercise [ ]hot flushes/flashing ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

tolerance [ ]breast discharges

Note: Fill out Section “O” only if you are pregnant or planning to be pregnant in the near future.

**Have you or the baby’s father or anyone in your families ever had any of the following:**

[ ]Down Syndrome (Mongolism)? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]Other Chromosomal abnormality? If yes, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]Neural tube defect( spina bifida, anencephaly)? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]Hemophilia or other coagulation abnormality? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]Muscular Dystrophy? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]Cystic Fibrosis? If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Father Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Mother Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] If you or the baby’s biological father are of African ancestry, have either of you been screened for

Sickle cell trait?

[ ] Father Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Mother Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] If you or the baby’s biological father are of Italian, Greek or Mediterranean background, have either of you been screened for B-thalessemia?

[ ] Father Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Mother Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]If you or the baby’s biological father are of Philippine or Southeast Asian ancestry, have either of you been screened for A-thalessemia?

[ ] Father Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Mother Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PATIENT SIGNATURE DATE TIME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

PROVIDER SIGNATURE DATE TIME