

# Medical Questionnaire

Reproductive Care of Indiana

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Chief Complaint/Reason for visit: \_\_\_\_\_

When was the first day of your last menstrual period: \_\_\_\_\_

How often do your periods come? \_\_\_\_\_ Are they regular? \_\_\_\_\_

How much pain or cramping do you have with your periods?  none  mild  moderate  severe

What pain medicine do you use for your cramps? \_\_\_\_\_

Are you using birth control now? \_\_\_\_\_

- If "Yes", what? (circle all that apply)  Pills  Condoms  Tubal  Depoprovera  other \_\_\_\_\_
- If "No", how long have you not been using birth control \_\_\_\_\_

Do you experience excess facial hair? \_\_\_\_\_

Have you ever had Chlamydia, gonorrhea, pelvic inflammatory disease or PID? \_\_\_\_\_ When? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

	Year	Baby born alive?	End in Miscarriage?	Tubal pregnancy?	End in abortion?	How long to conceive?	Fertility treatment required?	Is current partner the father?
1 <sup>st</sup> Pregnancy								
2 <sup>nd</sup> Pregnancy								
3 <sup>rd</sup> Pregnancy								
4 <sup>th</sup> Pregnancy								
5 <sup>th</sup> Pregnancy								

List any complications that you had with your pregnancies: \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_ Was it normal? \_\_\_\_\_

Have you had a mammogram? \_\_\_\_\_ If so, when was your last one? \_\_\_\_\_

List the medicines you know that you are allergic to: \_\_\_\_\_

List your current medications (both prescription and over-the-counter): \_\_\_\_\_

List all surgeries that you have had (include C-sections and D&C's) : \_\_\_\_\_

List any medical problems that you have: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs per day? \_\_\_\_\_