WILLIAM G. BUSH, M.D.
PATIENT MEDICAL HISTORY

Date ______________________

Name ____ **Birthday** ________________________ **Age** _________

Reason for today's visit? ____

THE FOLLOWING MEDICAL QUESTIONNAIRE IS CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE UNLESS *YOU* AUTHORIZE US TO DO SO.

MENSTRUAL HISTORY

Last Menstrual Period __________________ **Previous Menstrual Period** __________________ **Are your periods regular?** ☐YES ☐NO

Age menstruation began _______ **How often do you menstruate? Every** _____ **days** **How long do your periods last?** _______ **days**

Number of pads or tampons soaked in 24 hours on the heaviest day of bleeding? _______ **Cramps are:** ☐Mild ☐Severe ☐No Cramps

Do you have spotting between periods? ☐YES ☐NO **Do you have bleeding or spotting after intercourse?** ☐YES ☐NO

Do you douche? ☐ YES ☐ NO **How often?** __________________ **What douche preparation do you use?** __________________________

MEDICATIONS PRESENTLY TAKING

Name of Drug (If Known)	How Often?	Name of Drug (If Known)	How Often?
Aspirin			
Antiflamatory Meds			
Calcium			
Vitamins			

ALLERGIES

Are you allergic to any medications? ☐YES ☐ NO **If yes, please list** ____

CONTRACEPTIVE HISTORY

Are you using a Family Planning or birth control method now? ☐YES ☐NO **If no, Why?** ____________________________

Are you satisfied with this method? ☐ YES ☐ NO **If no, Why?** ____

OBSTETRICAL HISTORY

Total number of pregnancies: __________ **Number of Full Term Babies Born:** __________ **Number of Premature Babies Born:** __________

Number of Miscarriages or Abortions: ________ **Number of Living Children:** __________

List any previous complications DURING PREGNANCY: ____

Have you ever been treated for infertility? ☐YES ☐NO **If no, Why?** ____

SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES / NO				YES / NO		
D & C	☐ ☐	Date ________	Place ________________	Mastectomy	☐ ☐	Date ________	Place ________________
Colposcopy	☐ ☐	Date ________	Place ________________	Repair of Bladder	☐ ☐	Date ________	Place ________________
Conization	☐ ☐	Date ________	Place ________________	Appendectomy	☐ ☐	Date ________	Place ________________
Cryosurgery	☐ ☐	Date ________	Place ________________	Laparoscopy	☐ ☐	Date ________	Place ________________
Cesarean Section	☐ ☐	Date ________	Place ________________	Blood Transfusion	☐ ☐	Date ________	Place ________________
Hysterectomy	☐ ☐	Date ________	Place ________________	Any Other Operations:			
Removal of Ovaries	☐ ☐	Date ________	Place ________________	______________________		Date ________	Place ________________
Removal of Tubes	☐ ☐	Date ________	Place ________________	______________________		Date ________	Place ________________
Tubal Ligation	☐ ☐	Date ________	Place ________________	______________________		Date ________	Place ________________

Have you ever had to be put in the hospital for reasons other than childbirth or surgery? ☐YES ☐NO **Date** ______________________

Place ____ **Why** ____

Continue on other side

PAST MEDICAL HISTORY

HAVE YOU EVER HAD:	YES / NO	DATE/AGE of Onset
1. High Blood Pressure	☐ ☐	________
2. Diabetes	☐ ☐	________
3. Cancer	☐ ☐	________
4. Heart Trouble or Rheumatic Fever	☐ ☐	________
5. Hepatitis or Jaundice	☐ ☐	________
6. Kidney Disease or Bright's Disease	☐ ☐	________
7. Bladder Infection	☐ ☐	________
8. Asthma or Hay Fever	☐ ☐	________
9. Migraine Headaches	☐ ☐	________
10. Pneumonia	☐ ☐	________
11. Arthritis or Rheumatism	☐ ☐	________
12. Nervous Breakdown (or any emotional problem)	☐ ☐	________
13. German Measles	☐ ☐	________
14. Anemia	☐ ☐	________
15. Venereal Disease (Syphilis, Gonorrhea, Herpes, Condyloma or Venereal Warts)	☐ ☐	________
16. Infection of Tubes or Ovaries	☐ ☐	________
17. Vaginal Infections	☐ ☐	________
18. Endometriosis	☐ ☐	________
19. Epilepsy	☐ ☐	________
20. Thyroid Problem	☐ ☐	________
21. Stroke	☐ ☐	________
22. Do you have and bleeding tendency?	☐ ☐	________
23. Ulcers	☐ ☐	________
24. Gall Bladder Trouble	☐ ☐	________
25. Thrombophlebitis (Blood Clots in Veins)	☐ ☐	________
26. Tuberculosis	☐ ☐	________
27. Sickle Cell	☐ ☐	________
28. Any other serious illness?	☐ ☐	________
29. History of drug abuse?	☐ ☐	________
30. Have you ever had a "bad" Pap Smear?	☐ ☐	________

FAMILY HISTORY

Relationship	Age	Health Now	Age at Death	Cause of Death	Relationship	Age	Health Now	Age at Death	Cause of Death
Father					No. of Brothers				
Mother					No. of Sisters				

Has any blood relative (Parents, Grandparents, Brothers, Sisters, Children) ever had:

Breast Cancer ☐ YES ☐ NO Who ________________ Heart Trouble ☐ YES ☐ NO Who ________________

Cancer ☐ YES ☐ NO Who ________________ High Blood Pressure ☐ YES ☐ NO Who ________________

Diabetes ☐ YES ☐ NO Who ________________ Congenital Defects ☐ YES ☐ NO Who ________________

HABITS

1. Sleeping well? ☐ YES ☐ NO Average # of hours? ______ 2. Do you smoke tobacco? ☐ YES ☐ NO How much? __________

3. Alcoholic beverages? ☐ YES ☐ NO How much? __________ 4. Did you ever smoke? ☐ YES ☐ NO When did you quit? ______

5. Weight: Now: ________pounds One year ago: ________pounds Most you ever weighed: ________pounds When? __________

6. Last Medical Exam: Date ________________ Reason ________________________________ Date last Pap __________

Do you exercise regularly? ☐ YES ☐ NO

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Married (how long): _________ Husband's Name: ________________________ Age of Partner: _____ Health of Partner: ____________

Your signature ____ Date ______________________________