Women's Care of Beverly Hills Medical Group

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Name of Spouse/Partner: _____ Date of Birth: _____

E-mail: _____ Are you interested in e-mail communication? Y / N

Primary Phone: _____ Is this number ok to leave results messages? Y / N

Preferred Pharmacy and Phone Number: _____

Referred by: _____

Allergies to Medications (include reaction): _____

1. What brings you in for medical attention? Describe onset, duration, characteristics of and factors influencing your present illness.

_____

_____

_____

_____

2. Date of Last Menstrual Period: _____ Are periods regular? Y / N _____

What age did your periods first start? _____ What age did you reach menopause? _____

Do you suffer painful and/or heavy periods? _____

When was your last pap smear? _____ Have you had an abnormal pap? Y / N _____

Have you received Gardasil ® (HPV) vaccine? Y / N If so, all 3 shots? _____

When was your last mammogram? _____ Any abnormal mammograms? Y / N _____

When was your last colonoscopy? _____ When was your last bone density? _____

Do you use birth control? Y / N If yes, what kind? _____

Any history of STD's? (Herpes, Gonorrhea/Chlamydia) _____

3. Obstetric History: How many times have you been pregnant?_____

Number of children (if any):_____Miscarriages:_____Abortions:_____Ectopics:_____

Date	Type (vaginal/c-section)	Weight	Weeks (full-term?)	Complications	Name of Child

Are you planning a pregnancy? Y / N If so, when?_____

Any problems with infertility? Please explain:

_____

_____

5. Past Medical History: Do you have any chronic medical conditions (or have you been hospitalized)?

_____

_____

_____

What medications/herbs/hormones do you take on a regular basis?

_____

_____

_____

6. Past Surgical History: Have you ever had any surgeries? Please list procedures with year.

_____

_____

_____

7. Family History: Do you have any family history of cancer, high blood pressure, diabetes, stroke, heart disease? Please list relation, age at diagnosis and whether family member is living or deceased:

_____

_____

_____

_____

_____

_____

8. Social History: Do you smoke? Y / N If yes, how much?_____

Do you use alcohol? Y / N If yes, how much?_____

Do you use illegal drugs? Y / N If yes, how much?_____

Have you ever been physically or sexually assaulted? Y / N If yes, please explain:

_____

9. Have you ever had a serious or chronic condition of: If yes, please explain.

Eyes/Ears/Nose/Throat:_____

Thyroid/Skin:_____

Breasts:_____

Heart/Blood Clots/Blood Pressure:_____

Lungs:_____

Stomach/Intestine:_____

Bladder/Kidney: (Do you leak urine?)_____

Vulva/Vagina: (Problems with intercourse?)_____

Bones/Joints:_____

Nerves/Muscles:_____

10. Is there any other issue you would like to address with your provider today?

_____

_____

_____

RELEASE OF INFORMATION: I, the undersigned, authorize release of any information needed to act on this request.

MEDICARE RELEASE OF INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

ASSIGNMENT OF INSURANCE BENEFITS: I, the undersigned, hereby authorize to Women's Care of Beverly Hills for benefits payable due me under any terms of the insurance policy or policies that may cover professional services rendered to me. I understand that I am financially responsible to Women's Care of Beverly Hills for charges not covered by this authorization.

THE UNDERSIGNED AGREES TO ALL OF THE ABOVE:

Date_____Signed by:_____

From all of us at Women's Care of Beverly Hills, thank you for entrusting us with your care! Let us know how we can serve you better.

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