LONG BEACH OBSTETRICS &
GYNECOLOGY MEDICAL GROUP
MEDICAL QUESTIONNARE

Name _____ (please print) Age _____ Height _____ Date _____/_____/____

Occupation _____ Height (measured) _____

Doyou have, or have you had any of the following? (please **circle** all that apply)

High Blood Pressure	Diabetes	Stroke	Rheumatic Fever	Sexually Transmitted Disease	Birth Defects	High Cholesterol
Heart Disease	Cancer	Kidney Disease	Asthma/Chronic Lung Disease	Thyroid Disease	Migraines	

List all other past significant illnesses or conditions (except common colds, etc.): (please include **date** of onset if possible)

_____ _____ _____

List all surgeries (please include **date** if possible):

_____ _____ _____

List all significant hospitalizations (please include date and reason for hospitalization if possible):

_____ _____ _____

List all medications you are currently taking:

Medication	Strength	How often?	Medication	Strength	How often?

ALLERGIES: List all medications that you CANNOT take, and indicate what happened to you after taking the medication:

Medication	Type of Reaction	Medication	Type of Reaction

Please circle any medications you KNOW you CAN take: □ I have no known drug allergies

Penicillin Keflex or Ceclor Erythromycin Sulfa or Bactrim Codeine Aspirin

Please list major medical problems in your family:

Mother	Father	Sisters	Brothers	Children	Others

Has anyone In your family had any of the following (please **circle** all that apply) :

Blood clots (Iegs/lungs)	High Blood Pressure	Stroke	Heart Disease	Diabetes	Breast Cancer
Colon Cancer	High Cholesterol	Arthritis	Tuberculosis	Asthma	Ovarian Cancer
Other Cancers					

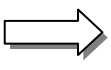
Circle one:	Single	Married	Separated	Divorced	Widowed

Circle one:	Heterosexual	Bisexual	Homosexual

Circle all that apply to you: Never Smoked Quit smoking mos. / yrs.ago Still smoke___packs per day:

**On average I have smoked ___packs a day for _____years.

Never drank alcohol Quit drinking ___years ago Drink only on occasion Drink__beers, drinks, or wine glasses_____days/week



Name _____ Date _____/_____/____
(please print)

OBSTETRIC HISTORY: Please list all pregnancies

Date (mo/yr)	Type of Delivery (vaginal/c section)	Indicate if ectopic, miscarriage or abortion	Sex	Weight	Complications

GYNECOLOGICAL HISTORY: Date of last Pap: / / Have you had any abnormal Paps?

Age at onset of menses: _____ Last menstrual period: / / Was it normal? Yes No

Usual number of days from first day of menses to first day of next menses: _____ Days of menstrual flow _____

Type of birth control you have used: _____ (circle current method)

Please circle all that apply:

General:

Weight loss	Weight gain	Skin Disease	Blood Clots	Fevers	Sweats
Fainting	Blackouts	Convulsions	Anemia	Easy Bleeding	Headaches
Sinus Disease	Nosebleeds	Asthma	Cough	Shortness of Breath	
Chest Pain	Heart Attack	Palpitations	Murmur	Abdomen Pains	Stomach Ulcers
Nausea	Vomiting	Constipation	Diarrhea	Vomiting Blood	Bloody Stools
Black Stools	Bowel Changes	Hemorrhoids	Hepatitis	Liver Disease	Kidney Disease
Molested as a child		Abusive Relationships		Will not accept lifesaving blood transfusion	

Gynecological:

Abnormal Pap	Cryosurgery	Genital Warts	Herpes	Frequent Yeast Infections
Gonorrhea	Chlamydia	Other Venereal Disease: _____		
Pelvic Pain	Severe Cramps	Hot Flashes	Irregular Bleeding	Breast Problems
Problems taking Estrogen		Problems with Intercourse		

Urine Problems:

Pain or Burning	Blood in Urine	Frequent Day-time Urination	Frequent Night-time Urination
Multiple Bladder or Kidney Infections		Loss of Bladder Control / Leakage of Urine	

If you did not circle an item listed above, you are indicating that it is not a significant problem for you.

Signature: _____