

**MID-ATLANTIC PELVIC SURGERY ASSOCIATES, P.C.  
PATIENT HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ Date \_\_\_\_\_ Age: \_\_\_\_\_

Please List Any Problems You Would Like to Talk About or Be Examined for:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Please Check Any of the Following Problems You Have or Recently Had:  
(Established Patients Please Check Problems Since Your Last Visit to this Office)**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Irregular Periods<br><input type="checkbox"/> Change in Menstrual Flow<br><input type="checkbox"/> Bleeding Between Periods<br><input type="checkbox"/> Bleeding During/After Sex<br><input type="checkbox"/> Painful Menstruations<br><input type="checkbox"/> Pain with Sexual Intercourse<br><input type="checkbox"/> Vaginal Discharge<br><input type="checkbox"/> Vaginal Dryness<br><input type="checkbox"/> Hot Flashes<br><input type="checkbox"/> Change in Sexual Desire<br><br><input type="checkbox"/> Fever<br><input type="checkbox"/> Weight Loss<br><input type="checkbox"/> Weight Gain<br><input type="checkbox"/> Change in Appetite<br><br><input type="checkbox"/> Blurred Vision<br><input type="checkbox"/> Double Vision<br><input type="checkbox"/> Eye Problems | <input type="checkbox"/> Dry Mouth<br><input type="checkbox"/> Problem Swallowing<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Swelling of Feet and Arms<br><input type="checkbox"/> Loss of Consciousness<br><br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Chronic Cough<br><input type="checkbox"/> Bringing Up Mucus<br><br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Abdominal Cramps, Pain<br><input type="checkbox"/> Blood in Stool<br><input type="checkbox"/> Nausea or Vomiting<br><input type="checkbox"/> Heartburn | <input type="checkbox"/> Frequent Urination<br><input type="checkbox"/> Urinary Urge<br><input type="checkbox"/> Painful Urination<br><input type="checkbox"/> Nightly Urination<br><input type="checkbox"/> Involuntary Urine Loss<br><input type="checkbox"/> Bloody Urine<br><br><input type="checkbox"/> Joint Aches, Pain<br><input type="checkbox"/> Joint Swelling<br><input type="checkbox"/> Muscle Aches, Pain<br><br><input type="checkbox"/> Rash<br><input type="checkbox"/> Skin Lesions<br><br><input type="checkbox"/> Breast Lumps<br><input type="checkbox"/> Breast Tenderness<br><input type="checkbox"/> Nipple Discharge | <input type="checkbox"/> Headaches<br><input type="checkbox"/> Weakness<br><input type="checkbox"/> Numbness<br><br><input type="checkbox"/> Mood Changes<br><input type="checkbox"/> Sleep Problems<br><input type="checkbox"/> Lack of Energy<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Memory Loss<br><br><input type="checkbox"/> Feel Hot or Cold<br><input type="checkbox"/> Usually Thirsty<br><br><input type="checkbox"/> Easy Bruising<br><input type="checkbox"/> Easy Bleeding<br><input type="checkbox"/> Swollen Lymph Glands<br><br><input type="checkbox"/> <b>All blanks are negative</b> |
|--|---|--|---|

**FOR ESTABLISHED PATIENTS ONLY**

Last Menstrual Period: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Las Pap: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Last Mammogram: \_\_\_\_\_ Other Physicians: \_\_\_\_\_  
 Last Colon Exam: \_\_\_\_\_  
 Last Chest X-ray: \_\_\_\_\_

Please List Illnesses, Surgery, Hospitalization and New Allergies Since Your Last Visit:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please List New Medications and Those You Stopped Since Your Last Visit:

- |            |                |
|------------|----------------|
| <u>NEW</u> | <u>STOPPED</u> |
| 1. _____   | 1. _____       |
| 2. _____   | 2. _____       |

Please List Changes in Marital Status, Employment, Smoking, Drug Use: \_\_\_\_\_

Please List Cancer Diagnosed in Your Family since Your Last Visit : \_\_\_\_\_