Children's Hospital, Boston - Division of Pediatric and Adolescent Gynecology
Initial Visit: Medical History Questionnaire

Date _____
Allergies _____
Medications (including herbal medications, vitamins, over the counter) :

Previous hospitalizations and surgery:

When:	Where:	For What?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you having menstrual periods? ❒ Yes ❒ No

When was your last menstrual period? _____

Do you have pelvic pain? ❒ Yes ❒ No
With bowel movements? ❒ Yes ❒ No
With urination? ❒ Yes ❒ No

How many days per month do you have pelvic pain? _____

On a 1-10 scale, what number is your pain when it is worst? _____

What relieves your pain? _____

How many days of school/work have you missed this year due to pain? _____

Family History: Please check each medical problem, if anyone in the family has or has had these problems.

- ❑ Alcohol/Drugs
- ❑ Anemia
- ❑ Asthma
- ❑ Blood Clots
- ❑ Cancer
- ❑ Depression
- ❑ Dermatitis
- ❑ Diabetes
- ❑ Eating Disorders
- ❑ Endocrine Problems
- ❑ Endometriosis
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease/Hepatitis
- ❑ Seizures
- ❑ Thyroid Disease
- ❑ Tuberculosis

Has a family member (including aunts and uncles) ever had a blood clot in their leg or arm? ❑Yes ❑No
Has a family member ever been hospitalized for a blood clot? ❒ Yes ❒ No
How old were they? _____ What happened? _____

Do you smoke cigarettes? ❒ Yes ❒ No Are there any smokers in your home? ❒ Yes ❒ No