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 ☐ Eating Disorders ☐ Liver
☐ Anemia ☐ Endocrine ☐ Disease/Hepatitis
☐ Asthma ☐ Problems ☐ Seizures
☐ Blood Clots ☐ Endometriosis ☐ Thyroid Disease
☐ Cancer ☐ Heart Disease ☐ Tuberculosis
☐ Depression ☐ High Blood Pressure
☐ Dermatitis ☐ Kidney Disease

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