Patient Label Here

Boston Children's Hospital, Division of Gynecology

Initial Visit: *Medical History Questionnaire*

Date_____ ____Patient identified by name or DOB

Allergies_____ Clinical Assistant Initial: _____

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

Previous hospitalization 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 do you have 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 circle each medical condition, Specify which family member has or has had these conditions (Siblings, parents, grandparents and blood-related aunts/uncles):

Medical Condition	**Family Member**	**Medical Conditions**	**Family Member**	**Medical Condition**	**Family Member**
Anemia		Pelvic pain		Kidney Disease	
Bleeding Disorder		Infertility		Liver	
Blood Clots		Heart Disease		Disease/ Hepatitis	
Breast Cancer		Heart Attack		Ovarian Cancer	
Diabetes		High Blood Pressure		Thyroid Disease	
Endometriosis		Stroke			

Has a family member (parents, grandparents, siblings, aunts or uncles) ever had a blood clot in their leg, arm, lung or brain? 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