Washington University Physicians
Washington University School of Medicine in St. Louis

MEDICAL HISTORY QUESTIONNAIRE

DEPARTMENT OF OBSTETRICS & GYNECOLOGY
DIVISION OF REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

Name: *(Last, First, M.I.):*		**Date of Birth:** *(month/day/year)*		**Today's Date:** *(month/day/year)*	
Who referred you to us/how did you hear about us?					
Reason for your visit today					
Are you trying to conceive or become pregnant?	☐ Yes ☐ No	If yes, how long without protection? *(yrs/mos)*			

MENSTRUAL HISTORY

Date of last menstrual period *(month/day/year)*		Age you started to have periods	
Are your cycles regular?	☐ Yes ☐ No	Number of cycles per year?	
Longest duration (days) between periods?		Shortest duration (days) between periods?	
On average, how many days between periods?		How long do your periods last (days)?	
Do you have painful periods?	☐ Yes ☐ No	Do you have abnormal bleeding?	☐ Yes ☐ No

GYNECOLOGICAL HISTORY

Have you used contraception in the past (birth control pills, contraceptive patch, IUD, condoms)	☐ Yes ☐ No		

Type of Contraception	Duration of Use

Have you been treated for a pelvic infection?	☐ Yes ☐ No	Have you had Herpes?	☐ Yes ☐ No
Have you had Gonorrhea?	☐ Yes ☐ No	Have you had HIV/ AIDS??	☐ Yes ☐ No
Have you had Syphilis?	☐ Yes ☐ No	Have you had Bacterial vaginosis (BV)??	☐ Yes ☐ No
Have you had Chlamydia?	☐ Yes ☐ No	Did your mother take DES?	☐ Yes ☐ No
Is there a history of physical abuse?	☐ Yes ☐ No	Were you born premature?	☐ Yes ☐ No
Is there a history of sexual abuse?	☐ Yes ☐ No	Birth weight *(pounds/ounces)*	
Did your mother require assisted reproduction to conceive you?	☐ Yes ☐ No	Date of last mammogram *(month/day/year)*	(/ /) ☐ None
Date of last PAP smear *(month/day/year)*		Was it normal?	☐ Yes ☐ No
Was it normal?	☐ Yes ☐ No	Do you have a history of abnormal hair growth?	☐ Yes ☐ No
History of abnormal PAP smear?	☐ Yes ☐ No	Do you have a history of PCOS (polycystic ovary syndrome)?	☐ Yes ☐ No
Have you had a cervical biopsy?	☐ Yes ☐ No	Do you have a history of POF/POI (premature ovarian failure/insufficiency?	☐ Yes ☐ No
What treatment for abnormal PAP?		Do you have a history of blocked tubes?	☐ Yes ☐ No
☐ Cryosurgery ☐ LEEP	☐ Cone biopsy	Do you have a history of tubal ligation?	☐ Yes ☐ No
Have you had a history of pelvic adhesions?	☐ Yes ☐ No	Do you have a history of a uterine abnormality?	☐ Yes ☐ No
Do you have a history of endometriosis?	☐ Yes ☐ No	Type of uterine abnormality?	
Do you have a history of uterine fibroids?	☐ Yes ☐ No		

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SEXUAL HISTORY

Frequency of intercourse *(per week)*		Do you use lubricants?	☐ Yes ☐ No

OBSTETRICAL HISTORY

List date *(month/year)*	**Outcome** ☐ Miscarriage ☐ Ectopic ☐ Vaginal delivery ☐ Caesarian delivery ☐ Abortion
_________ / ___________	**Comments:**
List date *(month/year)*	**Outcome** ☐ Miscarriage ☐ Ectopic ☐ Vaginal delivery ☐ Caesarian delivery ☐ Abortion
_________ / ___________	**Comments:**
List date *(month/year)*	**Outcome** ☐ Miscarriage ☐ Ectopic ☐ Vaginal delivery ☐ Caesarian delivery ☐ Abortion
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_________ / ___________	**Comments:**
List date *(month/year)*	**Outcome** ☐ Miscarriage ☐ Ectopic ☐ Vaginal delivery ☐ Caesarian delivery ☐ Abortion
_________ / ___________	**Comments:**

PRIOR INFERTILITY TREATMENTS (if applicable)

Clomiphene citrate	☐ Yes ☐ No	Number of cycles	
Intrauterine insemin.	☐ Yes ☐ No	Number of cycles	
FSH injectable meds	☐ Yes ☐ No	Number of cycles	
hCG injectable med.	☐ Yes ☐ No	Number of cycles	
IVF	☐ Yes ☐ No	Number of cycles	
Metformin	☐ Yes ☐ No	Dose	
Other: ____________________________	☐ Yes ☐ No	Dose	

PRIOR INFERTILITY EVALUATION (if applicable)

Urine ovulation predicator kits	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
FSH blood test	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Semen Analysis	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Hysterosalpingogram	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Laparoscopy	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Hysteroscopy	☐ Yes ☐ No	☐ Normal ☐ Abnormal	

Comments:

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CURRENT MEDICATIONS

Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers, etc.:

Name of Medication	Strength/Dose	Frequency Taken	Reason for Medication

CURRENT ALLERGIES

Allergies to Medications/Drug Sensitivities:

Name of Medication	Reaction to Medication

Allergies to Non-Medicines:
(Latex, adhesive tape, specific food allergies, etc.)

Allergy	Reaction

PAST MEDICAL HISTORY

Yes	No	Problem	Yes	No	Problem
☐	☐	Diabetes	☐	☐	Thyroid problems
☐	☐	High Blood Pressure	☐	☐	Asthma or other lung/pulmonary disorder
☐	☐	Lupus/ autoimmune disease	☐	☐	Arthritis
☐	☐	Bleeding or blood clotting disorder	☐	☐	Problems with anesthesia
☐	☐	Blood transfusion	☐	☐	Exposure to blood products
☐	☐	Blood clots, deep vein thrombosis or pulmonary embolus	☐	☐	Heart disease
☐	☐	Kidney disease	☐	☐	Infection
Other (explain)					

PAST SURGERY

List date / type of surgery / Reason / physician / hospital	

PAST HOSPITALIZATIONS

List date / diagnosis / physician / hospital	

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SOCIAL HISTORY

Occupation:		
Marital Status	☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed	
Do you currently consume alcohol?	☐ Yes Type: Frequency/Amount:	☐ No
Have you smoked at least 100 cigarettes in your entire life?	☐ Yes	☐ No
Do you now smoke cigarettes every day, some days or not at all?	☐ Every Day ☐ Some Days ☐ Not at All	
How many cigarettes do (did) you smoke per day, on average?	☐ 5 or fewer ☐ 6-15 (½ pack) ☐ 16-25 (1 pack) ☐ 26-35 (1½ pack) ☐ More than 36 (2 packs or more)	
Do you drink tea, coffee or other caffeinated beverages?	☐ Yes Type: Frequency:	☐ No
Do you use marijuana?	☐ Yes Frequency: # of years:	☐ No
Do you use IV drugs?	☐ Yes Type: Frequency: # of years:	☐ No
Do you exercise?	☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)	

FAMILY HISTORY

Has anybody in your family had any of the following? *(if YES, please list the family member)*:

Yes	No	Problem	Who?	Yes	No	Problem	Who?
☐	☐	Cancer		☐	☐	Heart disease	
☐	☐	High blood pressure		☐	☐	Breast Cancer	
☐	☐	Early menopause		☐	☐	Muscular dystrophy	
☐	☐	Ovarian Cancer		☐	☐	Sickle-cell anemia	
☐	☐	Cystic fibrosis		☐	☐	Mental retardation	
☐	☐	Tay Sachs		☐	☐	Neurologic disease	
☐	☐	Down's syndrome		☐	☐	Deafness	
☐	☐	Thyroid disease		☐	☐	Blindness	
☐	☐	Diabetes		☐	☐	Recurrent miscarriage	
☐	☐	Bleeding problems		☐	☐	Chromosome problem	
☐	☐	Lung disease		☐	☐	PCOS	
☐	☐	Obesity		☐	☐	Kidney disease	
☐	☐	Thalassemia		☐	☐	Anesthetic problems	
☐	☐	Blood Clotting Problems/deep vein thrombosis/ pulmonary embolus		☐	☐	Other	

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REVIEW OF SYSTEMS

Are you currently having any of the following:

Problem	Yes	No	Problem	Yes	No	Problem	Yes	No
Weight Loss	☐	☐	Breast pain	☐	☐	Abdominal pain	☐	☐
Weight Gain	☐	☐	Muscle weakness	☐	☐	Constipation	☐	☐
Fever	☐	☐	Joint pain	☐	☐	Blood in urine	☐	☐
Fatigue	☐	☐	Anxiety	☐	☐	Pain with urination	☐	☐
Autoimmune disease	☐	☐	Depression	☐	☐	Urgency	☐	☐
Hearing loss	☐	☐	Forgetfulness	☐	☐	Incontinence	☐	☐
Sinus problems	☐	☐	Eye disorder	☐	☐	Rashes	☐	☐
Dental problems	☐	☐	Vision change	☐	☐	Acne	☐	☐
Palpitations	☐	☐	Contacts/Glasses	☐	☐	Excess body hair	☐	☐
Mitral valve prolapse	☐	☐	Seizure	☐	☐	Non-healing sores	☐	☐
Chest pain	☐	☐	Headaches	☐	☐	Hot flashes	☐	☐
Swelling of legs/feet	☐	☐	Numbness	☐	☐	Night sweats	☐	☐
Easy bruising	☐	☐	Shortness of breath	☐	☐	Heat intolerance	☐	☐
Bleed excessively	☐	☐	Cough	☐	☐	Cold intolerance	☐	☐
Enlarged lymph node	☐	☐	Wheezing	☐	☐	Hair loss	☐	☐
Breast lump	☐	☐	Nausea/Vomiting	☐	☐	Thyroid problems	☐	☐
Nipple discharge	☐	☐	Diarrhea	☐	☐	Excessive thirst	☐	☐

IMMUNIZATIONS / GENETIC HISTORY

☐	☐	Have you had a rubella titer checked?	☐	☐	Have you had chicken pox?
☐	☐	Have you been screened for sickle cell disease?	☐	☐	Have you had a chicken pox vaccine?
☐	☐	Have you been screened for cystic fibrosis?			

SIGNATURES		DATE
Patient		
Attending Physician		

Please provide your preferred pharmacy phone number:

Mail order pharmacy information:

Please FAX your new patient packet forms to the
Attention of your physician at 314-286-2455 prior to
Your appointment.
Thank you

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PARTNER HISTORY (IF APPLICABLE)

Name: *(Last, First, M.I.):*		**Date of Birth:** *(month/day/year)*		**Age:**	
Occupation:					

Marital Status	☐ Single ☐ Married ☐ Partnered	☐ Separated ☐ Divorced ☐ Widowed	
Number of pregnancies with current partner		Number of pregnancies with previous partner(s)	
		Age (s) of children, if any:	
Do you currently consume alcohol?	☐ Yes Type:	Frequency/Amount:	☐ No
Have you smoked at least 100 cigarettes in your entire life?	☐ Yes		☐ No
Do you now smoke cigarettes every day, some days or not at all?	☐ Every Day	☐ Some Days ☐ Not at All	
How many cigarettes do (did) you smoke per day, on average?	☐ 5 or fewer ☐ 26-35 (1½ pack)	☐ 6-15 (½ pack) ☐ 16-25 (1 pack) ☐ More than 36 (2 packs or more)	
Do you drink tea, coffee or other caffeinated beverages?	☐ Yes Type:	Frequency:	☐ No
Do you use marijuana?	☐ Yes	Frequency: # of years:	☐ No
Do you use IV drugs?	☐ Yes Type:	Frequency: # of years:	☐ No
Do you use anabolic steroids?	☐ Yes	Frequency: # of years:	☐ No
Have you ever used anabolic steroids?	☐ Yes	Frequency: # of years:	☐ No
Did your mother require assisted reproduction to conceive you?	☐ Yes ☐ No	Were you born premature?	☐ Yes ☐ No
		Birth weight *(pounds/ounces)*	

MEDICAL PROBLEMS

CURRENT MEDICATIONS / CURRENT ALLERGIES (medication & non-medication)

Name of Medication	Strength/Dose	Name of Medication / Allergy	Reaction

SEXUAL HISTORY

Do you have a history of testicular injury?	☐ Yes ☐ No	Do you use lubricants?	☐ Yes ☐ No
Do you have difficulty with ejaculation?	☐ Yes ☐ No	Difficulty with intercourse?	☐ Yes ☐ No
Have you had a semen analysis?	☐ Yes ☐ No		

Results:

PAST SURGERY

List date / type of surgery / Reason / physician / hospital	

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PARTNER HISTORY – CONTINUED (IF APPLICABLE)

PAST HOSPITALIZATIONS

List date / diagnosis / physician / hospital	

FAMILY HISTORY

Has anybody in your family had any of the following? *(if YES, please list the family member)*:

Yes	No	Problem	Who?	Yes	No	Problem	Who?
☐	☐	Cancer		☐	☐	Heart disease	
☐	☐	High blood pressure		☐	☐	Breast Cancer	
☐	☐	Early menopause		☐	☐	Muscular dystrophy	
☐	☐	Ovarian Cancer		☐	☐	Sickle-cell anemia	
☐	☐	Cystic fibrosis		☐	☐	Mental retardation	
☐	☐	Tay Sachs		☐	☐	Neurologic disease	
☐	☐	Down's syndrome		☐	☐	Deafness	
☐	☐	Thyroid disease		☐	☐	Blindness	
☐	☐	Diabetes		☐	☐	Recurrent miscarriage	
☐	☐	Bleeding problems		☐	☐	Chromosome problem	
☐	☐	Lung disease		☐	☐	PCOS	
☐	☐	Obesity		☐	☐	Kidney disease	
☐	☐	Thalassemia		☐	☐	Anesthetic problems	
☐	☐	Blood Clotting Problems/deep vein thrombosis/ pulmonary embolus		☐	☐	Other	

SIGNATURES		**DATE**
Partner		
Attending Physician		