GENERAL MEDICAL HISTORY

Pope Paul VI Institute
6901 Mercy Rd.
Omaha, NE 68106-2604

NAME: _____

TODAY'S DATE:_____ DATE OF BIRTH:_____

ALLERGIES: _____

Prior to your first meeting with your physician, we would appreciate it if you could complete the following form to give us more information on your general health. This will allow us to be of better service to you.

PAST MEDICAL HISTORY

Please describe your general health at the present time:

_____

_____

CHECK EACH CHILDHOOD ILLNESS THAT YOU HAVE HAD:

❑ Measles ❑ German Measles ❑ Mumps ❑ Chicken Pox
❑ Rheumatic Fever ❑ Scarlet Fever ❑ Polio ❑ Diphtheria

Please check each immunization that you have received

❑ Measles ❑ Mumps ❑ Polio ❑ Tetanus Date of last immunization: _____

FAMILY HISTORY

Behind each family member, record the age and general health (or cause of death), including such things as: diabetes, tuberculosis, heart disease, high blood pressure, stroke, kidney disease, cancer (kind and location), anemia, headaches, mental illness, or symptoms like those of yourself (including such things as infertility problems, problems with repetitive miscarriages, stillbirths, premenstrual tension syndrome, etc.)

SPOUSE

Name: _____ Date of Birth: _____ Allergies: _____

Age: _____ General health (past and present): _____

_____

CHILDREN

Age: _____ General health: _____

_____

NAME: _____

TODAY'S DATE: _____ DATE OF BIRTH: _____

FATHER

Age: _____ General health: _____

MOTHER

Age: _____ General health: _____

BROTHERS

Age: _____ General health: _____

_____

SISTERS

Age: _____ General health: _____

_____

MATERNAL GRANDFATHER

Age: _____ General health: _____

MATERNAL GRANDMOTHER

Age: _____ General health: _____

PATERNAL GRANDFATHER

Age: _____ General health: _____

PATERNAL GRANDMOTHER

Age: _____ General health: _____

DO YOU HAVE A MOTHER, SISTER, OR AUNT WHO HAS HAD ANY OF THE FOLLOWING CANCERS?

1. Cervical Y N
2. Uterine Y N
3. Breast Y N
4. Ovarian Y N
5. Colon Y N

GENERAL HEALTH QUESTIONS

1. How many hours do you sleep at night? _____
2. Do you drink coffee? Y N If so, how many cups each day? _____
3. Do you drink cola? Y N If so, how many bottles/cans each day? _____
4. Do you drink tea? Y N If so, how many cups each day? _____
5. Do you eat chocolate? Y N If so, how much? _____

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GENERAL HEALTH QUESTIONS (CONT.)

6. Do you smoke? Y N If so, how many packs per day? _____
7. Do you drink alcohol? Y N If so, what amount? _____
8. Do you use any street drugs? Y N If so, what? _____
9. Have you ever had a venereal disease? Y N If so, what kind:
   ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis ❑ Cervical Dysplasia ❑ Herpes
   ❑ Genital Warts (condyloma) ❑ Trichomonas

BREAST INFORMATION

1. Have you ever breast-fed? Y N If so, how many times? _____
2. Do you do self breast exams? Y N
3. Have you ever had lumps, pain or discharge from your breasts? Y N
   If yes, which of the problems did you have? _____

BLADDER INFORMATION

1. Do you have any pain when you urinate? Y N
   If yes, how long have you had this? _____
2. Have you ever had blood in your urine? Y N
   If yes, how long have you had this? _____
3. Do you ever lose your urine when you cough, sneeze, or laugh? Y N
4. When you have to urinate, do you have extreme urgency to do so? Y N

POSTMENOPAUSAL INFORMATION

If you are in menopause, please answer the following questions:

1. When was your last menstrual period? _____
2. Have you had any bleeding since that menstrual period? Y N
   If yes, please describe the bleeding: _____
3. Are you taking any hormone replacement? Y N
   If yes, indicate what you are taking: _____

HORMONES

Do you have any of the following symptoms?

1. Excessive hair growth	Y	N
2. Skin rashes	Y	N
3. Muscle weakness	Y	N
4. Difficulty speaking	Y	N
5. Inability to concentrate	Y	N
6. Arthritic pains	Y	N
7. Hoarse voice	Y	N
8. Sinusitis	Y	N

NAME: _____

TODAY'S DATE: _____ DATE OF BIRTH:_____

HORMONES (CONT.)

9. Light-headedness	Y	N
10. Dry, scaly skin	Y	N
11. Hair falling out	Y	N
12. Loss of appetite	Y	N
13. Constipation	Y	N
14. Heavy menstrual bleeding	Y	N
15. Anemia (low blood)	Y	N
16. Puffy face	Y	N
17. Recent weight gain	Y	N
18. Recent weight loss	Y	N
19. Premenstrual syndrome	Y	N

VAGINAL DISCHARGES

1. Have you had any unusual vaginal discharges? Y N If yes, please describe:
   _____
2. Do you have pain or itching in the vaginal area? Y N If yes, please describe:
   _____
3. Do you have unusual vaginal bleeding? Y N If yes, please describe:
   _____

PAP SMEAR INFORMATION

4. When was your last pap smear? _____
5. Was your last pap smear normal? Y N If no, please describe:
   _____

ADDITIONAL GYNECOLOGICAL SYMPTOMS

Do you have any of the following symptoms?

1. Painful menstrual cramps	Y	N
2. Pain with intercourse	Y	N
3. Bleeding between periods	Y	N
4. Irregular or infrequent periods	Y	N
5. Heavy period	Y	N
6. Abnormal pap smear	Y	N

Thank you very much for completing this information.
By having this information, we can be of better service to you.

Prepared by

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