Center for Pediatric and Adolescent Gynecology

Lawrence Amesse, MD, PA

HEALTH HISTORY QUESTIONNAIRE

Welcome to Fertility Florida and the *Center for Pediatric and Adolescent Gynecology*. The enclosed questionaire that will help us facilitate you visit, and to provide more effective medical care.

Answer each question to the best of your ability by filling in the information or by marking the appropriate space. Don't worry if you are uncertain of the answer to some of the questions. You will have a chance to review them with the doctor. Please print legibly using a ballpoint pen as these forms will become a part of your permanent medical record.

Your answers will be treated confidentially, as are all aspects of your medical care.

Thanks and we look forward to working with you.

Center for Pediatric and Adolescent Gynecology
Lawrence Amesse, MD, PA

Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ Home phone: _____-_____

_____ FAX: (if available)_____-_____

_____ Email:_____

School/Grade: □ N/A _____ Employer: □ N/A _____

DRUG ALLERGIES: □NONE; LIST_____

REASON FOR YOUR VISIT

□ Pelvic Pain
□ Sexually Transmitted Diseases
□ Polycystic Ovary Syndrome
□ Abnormal Menstrual Periods
□ Lack of Menstrual Periods
□ Endometriosis
□ Ovarian Cysts/Dermoid etc
□ Excess Facial or Body Hair
□ Vaginal Discharge
□ Labial Adhesions
□ Contraception
□ Other_____

Please describe your present problem. Include all symptoms, how long you have experienced them and their patterns. Also indicate whether they have changed in severity over time:

_____

_____

_____

_____

PREVIOUS EVALUATION FOR PRESENT PROBLEM

Year Doctor's Name Tests & Results Treatments / Medications

_____

_____

_____

MENSTRUAL HISTORY

□ Not Applicable (N/A)

Age at onset: _____ What were the dates of your last two periods: _____

Are your cycles regular: Y / N Periods come every _____ days. # of days periods last: _____

Amount of bleeding and change during the period: _____

Painful periods (describe) ?_____

Bleeding between periods (describe) ?_____

Pain between periods ? If yes, explain _____

Have you ever received treatment to bring on or to regulate your periods? Y / N If yes, explain: _____

_____

GYNECOLOGIC HISTORY

Prior examinations: □ N/A

Date of last exam _____ Reason: _____

Date of last PAP smear _____ N/A _____

History of abnormal PAP Y / N Dates _____ Treatments _____

Have you had a history of (if yes, please give dates and type of treatments)

Milky breast discharge _____

Chlamydia _____

Pelvic infection _____

Other gynecologic problem _____

_____

_____

Birth control history: □ N/A

Method	Dates	Problems
IUD		
Pills		
Diaphragm		
Patch		
Condoms		
Nexplanon		
Depo-Provera		
Other		

PREGNANCY HISTORY: □ N/A

List all the pregnancies you have had, in chronological order, including miscarriages if applicable

_____

GENERAL HEALTH

List current medical problems: □ None

Date	Illness	Treatments

List surgeries you had: □ None

Date	Illness	Surgery

Medications you are currently on and medications you have taken regularly in the past: □ None

_____

_____

SOCIAL:

Alcohol consumption □ N/A _____ Cigarettes per day □ N/A _____
Caffeine (how much) □ N/A _____

FAMILY HISTORY:

List below the ages of your immediate living relatives, or their age at death if deceased, and their medical problems, if any, including medical problems and age at menopause.

Mother _____

Father _____

Brother(s)_____

Sister(s) _____

Grand parents _____

ADDITIONAL PATIENT COMMENTS: □ None

Please add any pertinent medical information not previously mentioned:

_____

_____

_____

Who referred you to our office?_____

If an other physician please indicate name and address below:

Referring physician: _____

Address: _____

_____

Office phone ____-_____

Patient's signature _____

Date _____