

South Shore/Hanover Obstetrics and Gynecology, Inc.

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Name: _____ Maiden Name: _____

Completion of this questionnaire will aid us in caring for you.
Check box if you have had the following, and elaborate in the right column. Thank you.

MEDICAL HISTORY	Explanation of Condition or Passed Illnesses
<input type="checkbox"/> 1. Rheumatic Fever <input type="checkbox"/> 2. Scarlet Fever <input type="checkbox"/> 3. High Blood Pressure <input type="checkbox"/> 4. Tuberculosis <input type="checkbox"/> 5. Diabetes	
<input type="checkbox"/> 6. Allergies to drugs or food?	
<input type="checkbox"/> 7. Anemia or bleeding problem?	
<input type="checkbox"/> 8. Heart Disease <input type="checkbox"/> a. Out of breath on exertion <input type="checkbox"/> b. Difficulty in lying flat <input type="checkbox"/> c. Pain on exertion or palpitation on exertion <input type="checkbox"/> d. Heart Murmur <input type="checkbox"/> e. Restricted in past because of heart disease <input type="checkbox"/> f. Varicose Veins <input type="checkbox"/> g. Cold, painful extremities	
<input type="checkbox"/> 9. Respiratory Diseases <input type="checkbox"/> a. Smoke; how much? <input type="checkbox"/> b. Pleurisy (Pain on breathing?) <input type="checkbox"/> c. Cough (severe or constant?) <input type="checkbox"/> d. Pneumonia or Bronchitis	
<input type="checkbox"/> 10. Bladder or Kidney disease?	
<input type="checkbox"/> 11. Gastrointestinal Disease <input type="checkbox"/> a. Diarrhea or Constipation <input type="checkbox"/> b. Peculiar stools <input type="checkbox"/> c. Gall bladder disease <input type="checkbox"/> d. Colitis <input type="checkbox"/> e. Ulcers <input type="checkbox"/> f. Liver disease (hepatitis)\	

___ 12. Bone, muscle, joint, nerve disease?	
___ 13. Psychiatric Illness	
___ 14. Glandular disease (such as Thyroid)	
___ 15. Blood Transfusion; when, how many?	
___ 16. Have you ever had an abnormal papsmear?	

FAMILY HISTORY
(DISEASES IN IMMEDIATE FAMILY SIMILAR TO PRECEEDING QUESTIONS)

Include congenital illnesses of husband's family.

Operations – Including tonsillectomy and D & C.

Is there anything else that you would like to discuss with the doctor?

Menstrual History

- a. Age of first period _____.
- b. Length of cycle _____.
- c. Last period _____.

HISTORY OF PREGNANCY

1. History of toxemia, excess weight gain or high blood pressure?

2. History of hemorrhage

3. History of Breech Delivery

4. History of Jaundiced Children

5. History of Pelvic or Kidney infections

6. Blood Type

PREGNANCIES

DATE	PLACE	LENGTH OF PREGNANCY	WEIGHT OF BABY	SEX	LENGTH OF LABOR	ANESTH.	COMPLICATIONS