HEALTH HISTORY QUESTIONNAIRE

INFORMATION CONTAINED HERE IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT. PLEASE BE AS COMPLETE AND DETAILED AS POSSIBLE.

NAME: ______________________________ Today's Date ______________

Date of last exam/pap ______________ Last Mammogram ______________

DEMOGRAPHIC DATA:

Marital Status ________ Age ________ Occupation ______________

Are you a student? ______ If so, where enrolled? ______________

What is the reason for your visit today? ______________

MEDICAL DATA:

Allergies to medication and reaction: ______________

____

MENSTRUAL HISTORY:

Last menstrual period: ______________

Type of birth control currently using: ______________ Are you happy with it? ______________

Menses: Age at onset: ______ How often: ______ Duration: ______ Amount of flow: ______

Do you have cramps? ______ If so, are they mild, moderate, severe? ______________

Do you bleed or spot between periods? ______ After intercourse? ______________

Has there been any change in the frequency of your sexual activity or sexual partner since your last visit? ______

If yes, please explain ______________

____

Is your relationship satisfactory? ______________

Have you ever been a victim of sexual abuse, domestic violence or rape? ______________

GYNECOLOGICAL HISTORY:

Please circle all of the following gynecologic conditions that you have or have had:

Abnormal pap smear	Chlamydia	Ovarian cyst	HIV	Herpes
Vaginal warts (HPV)	Gonorrhea	Endometriosis	Pelvic Surgery	Infertility
Urinary Leakage	Fibroids	Pelvic Infection		

PREGNANCIES:

Please list all pregnancies, deliveries, miscarriages and terminations.

Month & Year	Length of Pregnancy	Length of Labor	Cesarean or Vaginal	Birth Weight & Sex	Anesthesia Y/N	Complications (explain)

SURGERIES:

Please list all major and outpatient surgeries you have had:

Month & Year	Major or Outpatient	Type (explain)

(over)

MEDICAL PROBLEMS: (those requiring regular visits to a physician or requiring regular medication)

Please circle all of the following that apply to you:

Heart Disease	Bladder Infection	Kidney Infection	Heart Murmur	Ulcer
High Blood Pressure	Diabetes	Blood Clots	Epilepsy	Migraines
Eating Disorder	Lung Disease	Liver Disease	High Cholesterol	Cancer
Breast Disease	Thyroid Disease	Asthma	Mitral Valve Prolapse	

Other: ______________________________

____

PRESCRIBED MEDICATION & DOSAGE:

Please list all medications currently taking and the dosage:

Name of Medication	Dosage	Name of Medication	Dosage

OTHER MEDICATIONS & HOW OFTEN:

Aspirin __________ Tylenol (Acetaminophen) __________ Ibuprofen __________ Laxatives __________

Vitamins ______________________________ Herbal ______________________________

ANY RECENT SIGNIFICANT LIFE CHANGES:

Marriage __________ Childbirth __________ Family Disruption __________ Death in Family __________

Job Change __________ Change In Residence __________ Other ______________________________

HABITS:

Tobacco Use: Cigarettes (packs/day) __________ Smokeless (type) __________ Pipe __________

Alcohol (drinks per day or week) __________ Caffeine (glasses/cups per day) __________

Recreational drug use: ______________________________

Seatbelts: Circle one Always Sometimes Never

Do you exercise regularly? Yes No Specify activity & hours per week __________

Is your diet generally healthy? Yes No Do you get at least 4 servings of calcium a day? Yes No

Do you do regular breast self-examination? Yes No

When was your last tetanus shot? __________ When was your last cholesterol check? __________

FAMILY HISTORY:

Please list any medical problems in your family (such as diabetes, heart disease, high blood pressure, asthma, stroke, cancer especially breast, ovarian, uterine or colon, lung disease) or any birth defects.

RELATIONSHIP	AGE *(if living)*	ILLNESSES	AGE *(at death)*	CAUSE
Father				
Mother				
Siblings				
Children				
Spouse				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

PLEASE LIST ANY OTHER SYMPTOMS WHICH MAY BE BOTHERING YOU OR YOU MAY WISH TO DISCUSS.