

HEALTH HISTORY QUESTIONNAIRE

Patient's Name _____ Date of Birth _____ Today's Date _____

Allergies (medications, latex, food, iodine, etc.) _____

Describe reaction: _____

Gynecological History:

Menses (periods): What age did they begin? _____ What age did they end (menopause or hysterectomy)? _____

Your usual periods come every _____ days, lasting _____ days

The amount of bleeding is light average heavy

Your cramps/backache is very light moderate very severe

Female Problems: Do you have vaginal spotting or bleeding between periods? Yes No

Do you have problems with leaking urine or bladder concerns? Yes No

Do you have pain with sexual activity or other concerns about sexual functioning? Yes No

Do you have concerns about your moods or feeling of irritability? Yes No

Do you have hot flashes or problems sleeping? Yes No

Have you ever had a sexually transmitted disease (herpes, Chlamydia, GC, wart virus or HIV)? Yes No

Explain: _____

Have you ever had an abnormal pap smear or mammogram? Yes No

Explain: _____

Birth Control:

What birth control or contraception are you currently using?

- | | | |
|---|--|--|
| <input type="checkbox"/> none | <input type="checkbox"/> spermicide | <input type="checkbox"/> partner had vasectomy or is sterile |
| <input type="checkbox"/> birth control pills | <input type="checkbox"/> Depo-Provera ("the shot") | <input type="checkbox"/> tubal ligation or hysterectomy |
| <input type="checkbox"/> diaphragm or cervical cap | <input type="checkbox"/> withdrawal | <input type="checkbox"/> IUD (year placed _____) |
| <input type="checkbox"/> fertility awareness (rhythm) | <input type="checkbox"/> condoms | <input type="checkbox"/> other _____ |

Obsterical History:

List all your pregnancies

Year	Was it a miscarriage, ectopic, termination, normal delivery, or C-section?	Any complications?

Social History and Health Habits:

Smoking _____ cigarettes per day/week If ex-smoker, when did you quit? _____

Alcoholic Drinks _____ drinks/ week/ month If recovering alcoholic, sober since? _____

Street Drugs _____ times per day/ week/ months If recovering addict, clean since? _____

Caffeine use I use caffeine containing beverages or medications 3 or more times per day 1-3 times per day rarely

Diet: have healthy, low fat diet. My diet includes meat, fish or poultry dairy, eggs I am vegan

need to improve my diet

Exercise committed to exercising 5 or more times per week

do your best to be active or working out 2 -5 times per week

need to improve your activity level

Stress Level very low stress several stressors like family, work, money but feel in control

very stressful-feel overwhelmed

Seatbelt use always irregularly or infrequently rarely/never

Immunization When was your last diphtheria/tetanus shot _____

Self breast exams do them every month do occasionally

Sexual preference heterosexual bisexual lesbian prefer not to answer

Do you think you are at risk for HIV/AIDS? yes no

Are you in a possibly abusive, controlling or occasionally violent relationship? yes no

Does your partner have any serious medical, chemical dependency or mental health problems? yes no

Are you: married single divorced/separated widowed

With whom do you live? _____

*other questionnaire available

Past Medical History: Have you ever had:

- | | |
|--|---|
| <p style="text-align: right;">Details</p> <input type="checkbox"/> severe or frequent headaches _____
<input type="checkbox"/> visual or hearing problems _____
<input type="checkbox"/> thyroid problems _____
<input type="checkbox"/> diabetes _____
<input type="checkbox"/> lung problems (asthma, TB) _____
<input type="checkbox"/> high blood pressure _____
<input type="checkbox"/> strokes or blood clots _____
<input type="checkbox"/> heart problems _____
<input type="checkbox"/> breast cancer or other breast problems _____
<input type="checkbox"/> uterine, ovarian or cervical cancer- _____
<input type="checkbox"/> other types of cancer _____
<input type="checkbox"/> rape or sexual abuse _____
<input type="checkbox"/> infertility _____ | <p style="text-align: right;">Details</p> <input type="checkbox"/> excessive bleeding, bruising or blood transfusions _____
<input type="checkbox"/> high cholesterol _____
<input type="checkbox"/> liver problems (hepatitis, jaundice) _____
<input type="checkbox"/> stomach or intestinal problems (like ulcers, rectal bleeding) _____
<input type="checkbox"/> bladder or kidney problems (infections or stones) _____
<input type="checkbox"/> muscle, joint or bone problems (like osteoporosis)* _____
<input type="checkbox"/> skin problems _____
<input type="checkbox"/> eating disorder/mental health problems* _____
<input type="checkbox"/> seizures or neurological problems _____
<input type="checkbox"/> problem receiving anesthetics _____
<input type="checkbox"/> depression* _____
<input type="checkbox"/> other health concerns _____ |
|--|---|

Family History: Have any blood relatives had: **Circle One: M = Maternal P = Paternal**

- | | |
|---|---|
| <p style="text-align: right;">Who</p> <input type="checkbox"/> thyroid problems _____ M P
<input type="checkbox"/> diabetes _____ M P
<input type="checkbox"/> high blood pressure _____ M P
<input type="checkbox"/> stroke or blood clots _____ M P
<input type="checkbox"/> heart problems _____ M P
<input type="checkbox"/> breast cancer _____ M P
<input type="checkbox"/> uterine/ovarian cancer _____ M P
<input type="checkbox"/> colon cancer _____ M P
<input type="checkbox"/> skin cancer or melanoma _____ M P | <p style="text-align: right;">Who</p> <input type="checkbox"/> seizures or neurological problems _____ M P
<input type="checkbox"/> birth defects or inherited _____ M P
<input type="checkbox"/> eye disorders (like glaucoma) _____ M P
<input type="checkbox"/> osteoporosis _____ M P
<input type="checkbox"/> high cholesterol _____ M P
<input type="checkbox"/> chemical dependency _____ M P
<input type="checkbox"/> problems with anesthetics _____ M P
<input type="checkbox"/> other _____ M P |
|---|---|

Surgical History: Have you ever had:

- | | |
|--|--|
| <p style="text-align: right;">Year</p> <input type="checkbox"/> tonsillectomy _____
<input type="checkbox"/> dental surgery _____
<input type="checkbox"/> appendectomy _____
<input type="checkbox"/> gall bladder removal _____
<input type="checkbox"/> diabetes _____
<input type="checkbox"/> cesarean birth _____
<input type="checkbox"/> laparoscopy _____ | <p style="text-align: right;">Year</p> <input type="checkbox"/> surgery to cervix _____
<input type="checkbox"/> hysterectomy _____
<input type="checkbox"/> bladder surgery _____
<input type="checkbox"/> breast surgery _____
<input type="checkbox"/> tubal ligation _____
<input type="checkbox"/> other surgeries _____ |
|--|--|

Medication Use:

List all medications, including over the counter drugs like aspirin or laxatives that are used often, also list diet supplements, herbal preparations and homeopathic or natural remedies.

Name	Dosage	How often?	When did you begin?	Purpose