Nonnie M Estella MD, PC
10 Research Place, Suite 205
N. Chelmsford, MA 01863
978-459-8300

HEALTH AND HISTORY QUESTIONNAIRE

Date: _____

Name: _____ **Date of Birth**: _____ **Primary Care Physician**: _____

Medical History (Have you ever had any of the following?):

☐ Anemia	☐ Blood Clots in Lungs/Legs	☐ Epilepsy/Seizure Disorder	☐ Sickle Cell Disease
☐ Heart Disease/Attack	☐ Gallbladder Disease	☐ Migraines	☐ Tuberculosis
☐ High Blood Pressure	☐ Liver Disease/Hepatitis	☐ Depression/Anxiety	☐ Chicken Pox
☐ Stroke	☐ Kidney Infections/Disease	☐ Diabetes	☐ Genetic Condition
☐ High Cholesterol	☐ Bladder Infections/Disease	☐ Asthma	☐ Blood Transfusion
☐ Mitral Valve Prolapse	☐ Pelvic Infections/Masses	☐ Drug/Alcohol Problems	☐ Cancer (specify)
☐ Bleeding Problems	☐ Arthritis	☐ Thyroid Disorder	_____
☐ Seasonal Allergies	☐ Endometriosis	☐ Pneumonia	_____

List all allergies to medications: _____

☐ Check box if there are NO known allergies

List all medications you are currently taking, including over the counter medications, vitamins, and herbal remedies:

Medication	Strength	Frequency

List all surgeries, procedures you have had, including oral surgery:

Date	Surgery/Procedure

List all hospitalizations:

Date	Reason for Hospitalization

Family History (Please list all relatives with a history of the following):

Heart Disease/Attack		Gallbladder Disease		Genetic Condition	
High Blood Pressure		Liver Disease/Hepatitis		Cancer (specify)	
Stroke		Kidney Disease			
High Cholesterol		Bladder Disease		Other (specify)	
Emboli/Blood clots		Thyroid Disorder			
Bleeding Problems		Autoimmune Diseases			
Epilepsy/Seizures		Breast Cancer			
Migraines		Colon Cancer			
Depression/Anxiety		Ovarian Cancer			
Diabetes		Uterine Cancer			
Asthma		Substance abuse			

Occupation: _____

Check one: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gynecological/Obstetrical History:

Age of first menses/period:_____
Cycles occur every ___ days, lasting ___ days

Age of menopause:_____
Pain with menses? Y/N ◯◯
Ovarian cysts: Y/N ◯◯

Last menstrual cycle:___/___/___
Heavy flow? Y/N ◯◯
Uterine fibroids? Y/N ◯◯

Sexual reference: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Sexually active: ☐ Yes ☐ No ☐ Virginal

Method of Birth Control:

☐ None
☐ Condom
☐ Oral/ Pill, Brand:
☐ OrthoEvra Patch
☐ Vaginal Ring
☐ Tubal ligation/Essure
☐ IUD
☐ Depo-Provera Injection
☐ Partner had vasectomy
☐ Natural family planning

Have you ever had any of the following sexually transmitted infections?

☐ Chlamydia
☐ Gonorrhea
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes simplex (HSV)
☐ HIV
☐ HPV (Human Papilloma Virus)
☐ Syphilis
☐ Trichomonas
☐ Never had any

Date of last pap smear: ___/___/___
Have you ever had an abnormal pap? Y/N ◯◯ If you did, did you have a LEEP/conization procedure? Y/N ◯◯

Date of last mammogram: ___/___/___ ☐ Normal ☐ Abnormal ☐ Never had one
Date of last bone density: ___/___/___ ☐ Normal ☐ Abnormal ☐ Never had one

Obstetrical History (Please list all pregnancies including miscarriages, stillbirths, ectopics, and abortions):

Year	M/F	Weight	Vaginal/Csection	Months @ Birth	Problems/Complications	Child's Name

Social History:

Alcohol Use: Y/N ◯◯ If Yes,_____drinks per day/week
Tobacco Use: Y/N ◯◯ If Yes,_____packs per day for ___ years
Street Drug Use: Y/N ◯◯ Type and frequency _____

Exercise:Y/N ◯◯ Type and frequency _____
Caffeine: Y/N ◯◯ If Yes,____caffeinated drinks per day/week

Sexual Abuse: Y/N ◯◯ If Yes, are you safe now? Y/N ◯◯ Counseling? Y/N ◯◯
Physical Abuse: Y/N ◯◯ If Yes, are you safe now? Y/N ◯◯ Counseling? Y/N ◯◯
Emotional Abuse: Y/N ◯◯ If Yes, are you safe now? Y/N ◯◯ Counseling? Y/N ◯◯

Review of Systems (Do you currently have any of the following?):

☐ Generally healthy
☐ Depression/Anxiety
☐ Recent Weight gain or loss of 20lbs
☐ Fever
☐ Vision changes
☐ Sinus problems
☐ Hearing loss
☐ Joint/Muscle pain
☐ Varicose veins
☐ Shortness of breath
☐ Chest pain
☐ Chronic cough
☐ Diarrhea
☐ Constipation
☐ Blood in stools
☐ Heartburn/Reflux
☐ Frequent urination
☐ Burning with urination
☐ Incontinence
☐ Urgency
☐ Stomach bloating/pain
☐ Vaginal discharge
☐ Irregular bleeding
☐ Pelvic pain
☐ Pain/bleeding with intercourse
☐ Breast lumps
☐ Back pain

Family History

	Alive/Deceased	Illnesses, Conditions, Cancers
Mother	◯◯	
Father	◯◯	
Maternal Grandmother	◯◯	
Maternal Grandfather	◯◯	
Paternal Grandmother	◯◯	
Paternal Grandfather	◯◯	
Siblings	◯◯	