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**HEALTH AND HISTORY QUESTIONNAIRE**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**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:**

<u>Medication</u>	<u>Strength</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Date</u>	<u>Surgery/Procedure</u>
_____	_____
_____	_____
_____	_____

**List all hospitalizations:**

<u>Date</u>	<u>Reason for Hospitalization</u>
_____	_____
_____	_____
_____	_____

**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          | _____ | Other (specify)   | _____ |
| High Cholesterol     | _____ | Bladder Disease         | _____ | _____             | _____ |
| 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):

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

**Social History:**

Alcohol Use: Y/N     If Yes, \_\_\_\_\_ drinks per day/week     Exercise: Y/N     Type and frequency \_\_\_\_\_  
 Tobacco Use: Y/N     If Yes, \_\_\_\_\_ packs per day for \_\_\_ years     Caffeine: Y/N     If Yes, \_\_\_\_\_ caffeinated drinks per day/week  
 Street Drug Use: Y/N     Type and frequency \_\_\_\_\_

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

**Family History**

	<u>Alive/Deceased</u>	<u>Illnesses, Conditions, Cancers</u>
<b>Mother</b>		
<b>Father</b>		
<b>Maternal Grandmother</b>		
<b>Maternal Grandfather</b>		
<b>Paternal Grandmother</b>		
<b>Paternal Grandfather</b>		
<b>Siblings</b>		