HEALTH HISTORY QUESTIONNAIRE

The health history questionnaire you are about to fill out is important. It gives us information about your health, which will enable us to spend more time discussing your medical condition. It will become part of your medical record and will remain confidential.

Name: _____Age: _____Birth date: _____

Who referred you to this office? _____

Who is your primary care physician? _____

Your previous OB/GYN was: _____

What is your reason for coming to the doctor today? _____
_____
_____

Have you seen a doctor for this problem in the past? Who? _____

Please check items that apply to you:

_____ Migraine headaches
_____ Neurologic disorders
_____ Thyroid Problems
_____ Heart Condition
_____ Cholesterol disorders
_____ Lung Disorders
_____ Jaundice, Hepatitis, Liver Problems
_____ Stomach, Bowel, Gallbladder Problems
_____ Anemia or Blood Disorders
_____ Diabetes
_____ Birth Defects, Inherited Diseases
_____ Depression or Psychiatric Disorders
_____ Cancer
_____ Abnormal Pap Smear

Current Medications:
_____
_____
_____
_____

List Medication Allergies:
_____
_____
_____
_____

HOSPITALIZATIONS AND OPERATIONS

No.	Month/Year	Illness or Operation	Complication?
1.			
2.			
3.			
4.			

OBSTETRICAL HISTORY

Pregnant how many times? _____
Number of Full Term babies? _____
Number of Premature babies? _____

Abortions? _____
Miscarriages? _____
How many still living? _____

Child No.	Born Month/Year	Baby's Information Weight	Sex	Type of Delivery	Complications Explain
1.					
2.					
3.					
4.					

MENSTRUAL HISTORY

When was the first day of your last period? _____
Was your last period normal? _____
Age at which you began having periods? _____
Are your periods regular? _____

How often do you have periods? _____
How many days do you have flow? _____
Do you have problems with PMS? _____
Date of most recent pap? _____

BREAST HISTORY

Have you had any breast biopsies? _____
Problems with severe breast pain? _____

Nipple Discharge? _____
Do you feel any breast masses? _____

SEXUAL HISTORY

Are you sexually active? _____
What kind of birth control do you use? _____
Have you ever been diagnosed with a Sexually Transmitted Disease? _____

Do you have any problems in your sex life? _____
Do you have any questions about sex? _____

SOCIAL HISTORY

Do you smoke? How much? _____
Do you drink alcoholic beverages every day? _____
Do you use recreational drugs? _____
Are you in a relationship with a person who Threatens or physically hurts you? _____

BLADDER HISTORY

Do you leak urine when you cough, sneeze, or exercise? _____
Do you have problems with frequent bladder infections? _____
Does your urine sometimes smell very bad? _____
Do you leak urine when walking to the bathroom? _____
How often do you get up at night to urinate? _____

FAMILY HEALTH

Does anyone in your family have any of these conditions?

Breast Cancer _____ Who? _____
Ovarian Cancer _____ Who? _____
Colon Cancer _____ Who? _____
Diabetes _____ Who? _____
Bleeding Disorder _____ Who? _____
Heart attack before age 50 _____ Who? _____

Indicate if any of the following applies to you: _____ YES _____NO

a.) Blood transfusion between 1977 and 1991
b.) Sexual contact with a person with AIDS
c.) Current or past IV drug use
d.) Current or past sexual partner who is bisexual, hemophiliac or IV drug user

Is there any other medical information we need to know?

_____
_____
_____
_____
_____
_____

_____
Patient Signature Date

Drivers License #_____State_____

Revised 2/18/09