

Today's Date: ____/____/____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ **Age:** _____ **DOB** ____/____/____
(Last, First, M.I.)

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor: _____ **Date of Last Pap Test:** ____

PERSONAL HEALTH HISTORY

PMS Symptoms : Mood Swings Irritability Tension/Anxiety Depression Breast Pain Bloating
 Feeling out of control/ overwhelmed Symptoms occurring 1-2 wks. Before period

Menopause Symptoms : Hot Flashes Memory/Concentration
 Vaginal Dryness _____ Night Sweats _____

Sexual Problems : Libido Orgasmic Dysfunction Pain w/intercourse
 Other _____

Age at onset of menstruation: ____ Date of last menstruation: ____/____/____
Period every ____ days. Heavy periods, irregularity, spotting, pain or discharge?..... Yes No
Number of pregnancies ____ Number of live births ____
Contraceptive Method _____
Are you pregnant or breastfeeding? Yes No
Have you had a D&C, hysterectomy or cesarean? Yes No
Any urinary tract, bladder or kidney infections within the last year? Yes No
Any blood in your urine? Yes No
Any problems with control of urination? Yes No
Experienced any recent breast tenderness, lumps or nipple discharge? Yes No

List Any Medical Problems That Other Doctors Have Diagnosed:

Pregnancy History

Year	Duration	M/F	Weight	Complications

Surgeries/Other Hospitalizations:

Year	Reason	Hospital

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

HEALTH HABITS

Exercise: Sedentary (No exercise) Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
 Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Caffeine: None Coffee Tea Cola # of Cups/Cans Per Day? _____

Alcohol: Do you drink alcohol? Yes No
 If yes, what kind? _____ How many drinks per week? _____

Tobacco: Do you use tobacco? Yes No
 Cigarettes - Pks/day _____ # of Years _____ or Year Quit _____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____ <input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Circulation _____ Recent Changes In: <input type="checkbox"/> Weight _____	<input type="checkbox"/> Energy Level _____ <input type="checkbox"/> Ability to Sleep _____ Other Pain/Discomfort: _____ _____ _____
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FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
				<i>Male</i> _____			
				<i>Female</i> _____			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i> _____			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i> _____			