Date:

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Breasts	☐Excessive Tenderness ☐ Cysts ☐Discharge from nipples ☐Enlargement ☐Benign Breast Lumps ☐ Breast Cancer ☐ Breast Surgery (include Date)
Have you ever been treated for these Infections?	☐ Syphilis ☐ Gonorrhea ☐ Herpes ☐ Recurrent Vaginitis ☐ Genital ☐ Oral ☐ Chlamydia ☐ Bartholin Cyst ☐ Pelvic Inflammatory Disease

List any medical problems that other doctors have diagnosed

Gynecological and Other Surgeries

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

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

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)				
Diet	Are you dieting?			□ Yes	□ No
	If yes, are you on a physician prescribed medical diet?			□ Yes	□ No
	# Of meals you eat in an average day?				
	Rank salt intake	□ Hi	□ Med	□ Low	
	Rank fat intake	□ Hi	□ Med	□ Low	
Caffeine	☐ None	□ Coffee	□ Tea	□ Cola	
	# Of cups/cans per day?				
Tobacco	Do you use tobacco?			□ Yes	□ No
	□ Cigarettes – pks. /day				
	□ # Of years	□ Or year quit			
Sex	Are you sexually active?			□ Yes	□ No
	If yes, are you trying for a pregnancy?			□ Yes	□ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			□ Yes	□ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			□ Yes	□ No
Personal Safety	Do you live alone?			□ Yes	□ No
	Do you have frequent falls?			□ Yes	□ No
	Do you have vision or hearing loss?			□ Yes	□ No
	Do you have an Advance Directive and/or Living Will?			□ Yes	□ No

DO YOU HAVE A HISTORY OF:

□ Ovarian Cyst	□ Abnormal Uterine Bleeding
□ Exposure to DES	□ Endometriosis
□ Infection of Uterus, Tubes, Ovaries	□ Infertility

WOMEN ONLY

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		
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
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap?		
Date of Last Mammogram?		
Date of Last Colonoscopy?		
Date of Last Bone Density?		

MEDICAL HEALTH

High Blood Pressure	☐	Yes	☐	No
Diabetes	☐	Yes	☐	No
Heart Disease	☐	Yes	☐	No
Lung Disease	☐	Yes	☐	No
Allergies	☐	Yes	☐	No
Liver Disease	☐	Yes	☐	No
Kidney Disease	☐	Yes	☐	No
GI Disease (ulcers, colitis)	☐	Yes	☐	No
Have you ever had a blood Transfusion?	☐	Yes	☐	No

OTHER PROBLEMS

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

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	