HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Marital Status: ☐ Single ☐ Married (How many Years: _____) ☐ Divorced ☐ Widowed

Reason you came to see the doctor: _____

List any Medication you are **ALLERGIC** to:

_____

_____

Check or List any Medical Problem that applies to you:

☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes
☐ Asthma/Lung Disease ☐ Kidney Disease ☐ Bleeding Disorder
☐ Breast Disease ☐ Cancer ☐ Depression/Mental Illness
Other/Remarks: _____

List Medicines you are currently taking:

_____

_____

_____

_____

List any OPERATIONS you have had and the year it took place:

_____

_____

_____

_____

Menstruation: Started at age _____, Number of days from start of one period to start of next period _____ .
Number of days period lasts _____ . Date of last normal menstrual period (1st day) _____ .

Obstetrical History: How many times have you been pregnant? _____ .
How many Full-term babies? _____ , Premature? _____ , Miscarriages? _____ , Abortions? _____ .

Date of Birth	Weeks Pregnant	Weight	Sex M/F	Type of Delivery (Vaginal, C-section, Forceps, …)	Place/Doctor	Complications?/Remarks?

Last Pap Smear: _____ Results: _____ Any History of Abnormal Pap Smear? _____

Do you smoke? If so, how much per day? _____. Do you drink? If so, how much per week? _____.

Please check <u>YES</u> after the following questions if they apply to you

Are your periods irregular?	☐ YES	Is your appetite poor?	☐ YES
Are they painful?	☐ YES	Do your ankles swell?	☐ YES
Do you bleed between periods?	☐ YES	Do you have varicose veins?	☐ YES
Is intercourse painful/uncomfortable?	☐ YES	Do you get shortness of breath?	☐ YES
Are you troubled with a vaginal discharge?	☐ YES	Do you get chest pain?	☐ YES
Does it itch or irritate you?	☐ YES	Do you get hot flashes?	☐ YES
Do you urinate too often?	☐ YES	Do you get headaches?	☐ YES
Do you get up at night to urinate?	☐ YES	Do you sleep poorly?	☐ YES
Do you pass blood in the urine?	☐ YES	Have you ever had a blood transfusion?	☐ YES
Do you lose urine when you cough, laugh or sneeze?	☐ YES	Are you depressed?	☐ YES
Does it feel like anything is pushing out of your vagina?	☐ YES	Have you ever been treated for nerves?	☐ YES
		Have you ever been hospitalized for anything else?	☐ YES
Are you constipated?	☐ YES	REMARKS: _____	
Do you have difficulty with your bowels or bladder	☐ YES	_____	
Do you have blood in your stools?	☐ YES	_____	
Have you gained or lost weight?	☐ YES	_____	

Current age of Mother (or age died & cause): _____ Father: _____
Record Family History of any medical problems including Heart Disease, Diabetes, Cancer, Birth Defects, etc._____
_____