HEALTH QUESTIONNAIRE

NAME:

AGE: DATE OF BIRTH:

ADDRESS:

PHONE: Home:

Work:

LIST ANY DRUGS YOU ARE ALLERGIC TO
1)
2)
3)
4)

WHAT IS THE REASON FOR YOUR DOCTOR'S APPOINTMENT?

1. Yearly
2. Other (please specify)

WHEN WAS YOUR LAST PAP SMEAR?

WHEN WAS YOUR LAST MAMMOGRAM?

MENSTRUAL HISTORY:

How old were you when you first started menstruating?

When was your last menstrual period?

If it has been longer than one year since your last menstrual period, skip the next questions.

How often do you have a period?

How long do your periods last?

The flow is usually (circle one) light moderate heavy

Do you have cramping? Yes No

If yes, what medication do you take for the cramping?

Have you ever had sexual intercourse?

If yes, what method of contraception have you used in the past?

Tubal Ligation Vasectomy Pills IUD Depoprovera Condoms Diaphragm

Sponge Rhythm Nuva-Ring Ortho-Evra Patch Other:

What do you presently use?

Name_____

PREGNANCY

Have you ever been pregnant?

If yes: How many times have you been pregnant?

How many living children do you have?

How many miscarriages or abortions have you had?

For each child born living, please complete the following.

	1st	2nd	3rd	4th	5th
YEAR BORN					
SEX					
BIRTH WEIGHT					
VAGINAL OR C-SECTION					
BORN EARLY OR LATE					
HOW MUCH EARLY OR LATE					
LENGTH OF LABOR					
COMPLICATIONS					

FEMALE SURGERY:

Give dates of any of the following female surgeries you have had performed:

Tubal ligation (tubes tied to prevent pregnancy)

Hysterectomy (removal of the uterus) Yes No

Abdominal or Vaginal

Removal of ovary (ies) Right Left Both Don't know

Laparoscopy

Bladder surgery

Rectal Surgery

Cryotherapy (freezing) of the cervix

LEEP

Other female surgery

Name_____

FEMALE DISEASES:

Have you received the HPV (papilloma virus) vaccine? Yes No

Did you complete all 3 injections? Yes No Date of Vaccine

Have you had:

Cancer of the cervix
Cancer of the uterus
Cancer of the ovary
Cancer of the breast
Abnormal pap smears
Endometriosis
Infections: (circle any that you have had in the past)

syphilis gonorrhea chlamydia condyloma (warts)
herpes AIDS (HIV) High Risk HPV

Leakage of urine
Urinary tract (bladder) infections

NON-FEMALE MEDICAL HISTORY

List any previous surgery and give dates.

1.
2.
3.

List the reason for any other hospitalizations you have had, give dates and length of stay.

1.
2.
3.

List any prescribed medication you take, the dosage, and the reason.

1.
2.
3.

Have you ever had a Blood Transfusion?

Circle any of the following conditions you presently have or have had in the past.

Migraine Headaches	Kidney Disease
Heart Disease	Blood Disorder
Hypertension	Phlebitis
Respiratory Disease	Skin Disease
Breast Disease	Diabetes
Hepatitis/Jaundice	Thyroid Disease
Gallbladder Disease	Cancer
Ulcers	Epilepsy
Bowel Disorders	

Name _____

SOCIAL HISTORY

Do you smoke?

How many cigarettes per day?

Do you drink alcohol?

How many ounces per week?

Do you use any street drugs?

FAMILY HISTORY

Have any of the following had Breast Cancer, and what were their ages when diagnosed?

Mother_____ Age_____

Sister_____ Age_____

Daughter_____ Age_____

Grandmother_____ Age_____

Maternal Grandmother_____ Age_____

Maternal Aunt_____ Age_____

Have any of the following relatives suffered from a heart attack at less than 50 years of age?

Mother_____ Father_____ Sibling_____

Do any of the following take medications to control high cholesterol?

Mother_____ Father_____ Sibling_____

List any known birth defects, genetic disease, or mental retardation in family members.

(Please specify as much as you know about the type.)

I VERIFY THE HEALTH INFORMATION PROVIDED IS COMPLETE AND ACCURATE.

Patient Signature Date Physician Initials