

HEALTH HISTORY QUESTIONNAIRE

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

PLEASE COMPLETE BOTH SIDES

Name _____ Date of Birth _____
 Age _____ Race _____ Primary Language _____ Occupation _____
 Reason for today's visit _____ Primary Care Physician _____

Reproductive History: Menstrual Cycle

1st day of last period _____ Age of 1st period _____
 If menopausal, age of onset: _____ On HRT? _____ Medication Name _____
 How often do you get your menstrual cycle? Every _____ days, lasting _____ days.
 Are your cycles? _____ Regular _____ Irregular _____ Heavy _____ Moderate _____ Light
 Are you sexually active? _____ Never _____ Not Currently _____ Yes
 Method of contraception:
 _____ None _____ Tubal Ligation _____ Vasectomy _____ Rhythm Method
 _____ Nexplanon _____ NuvaRing _____ IUD (Mirena/Paraguard) _____ Patch _____ Pill
 _____ Depo Provera _____ Condoms _____ Other _____

Obstetrical History (Please list all pregnancies, including miscarriages, ectopic and abortions)

EXAMPLES: **Type:** vaginal, C/S, forceps or vacuum **Anesthesia:** epidural, local, general, spinal **Complications:** preterm labor, diabetes, bleeding, high blood pressure, postpartum depression

PAST PREGNANCIES

	Date	Weeks	Length of labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location
EX:	1/15/1975	40	12 hrs	6lb. 2oz.	F	Vaginal	Epidural	HBP. Gest. Diabetes	BRH
1)									
2)									
3)									
4)									
5)									

Do you have any Adopted Children or Foster Children? _____ YES _____ NO

Well Woman Update (Please provide dates where applicable)

Bone Density Exam _____ (year) Any Abnormal Pap smears? _____ YES _____ NO
 Colonoscopy _____ (year) Cervical Dysplasia (precancerous cells of the cervix) _____ YES _____ NO
 Mammogram _____ (year) If yes, treatment dates:
 Pap Smear _____ (year) LEEP _____
 HPV/ Gardasil Vaccine series completed _____ YES _____ NO Cryo (freezing) _____
 Have you had the Hepatitis B series? _____ YES _____ NO Cone Biopsy _____
 Colposcopy _____

Medical History: Do you now have or have you ever had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> DVT / PE | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Herpes | <input type="checkbox"/> Osteopenia / Osteoporosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> IBS / IBD | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pelvic Inflamm. Disease |
| <input type="checkbox"/> Bone/Joint Disease | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer (type?) _____ | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> HPV/Genital warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Kidney Stones/Infection | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Diabetes Type I / II | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Tuberculosis |

Other: _____

Surgical History Please list ALL surgical procedures, including year (attach additional paper if necessary)

- 1) _____ 2) _____
 3) _____ 4) _____

Medications & Allergies Current Med & Dosage

(attach additional paper if necessary)

- 1) _____
 2) _____
 3) _____
 4) _____

Vitamins/ Herbal Supplements (including CBD oil/teas)

Drug Allergies / Reaction _____

Family History Include age of onset if known

ILLNESS	Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Sibling/Other (Please specify)
Cancer (type)							
Diabetes (type)							
Heart Disease							
Other							

Social History

_____ Married _____ Single _____ Engaged _____ Same Sex Partner _____ Divorced _____ Widowed

Tobacco Use? _____ Never _____ Current _____ Former, Quit at age _____ Alcohol Use? _____ YES _____ Drinks per week _____ NO

Drug Use? (including Medical Marijuana) _____ YES _____ NO Type used and last use _____

Any history of violence or abuse in your current household or in your past? _____ YES _____ NO

Do you have any cultural or religious considerations that need special attention? _____ YES _____ NO

Emergency Contact Name _____ Phone # _____

SIGNATURE _____ **DATE** _____

