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)

Colonoscopy _____ (year)

Mammogram _____ (year)

Pap Smear _____ (year)

HPV/ Gardasil Vaccine series completed ____ YES ____ NO

Have you had the Hepatitis B series? ____ YES ____ NO

Any Abnormal Pap smears? _____ YES _____NO

Cervical Dysplasia (precancerous cells of the cervix) ____ YES ____ NO

If yes, treatment dates:

LEEP _____

Cryo (freezing) _____

Cone Biopsy _____

Colposcopy _____

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

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