



Date: _____

This information is confidential. We appreciate your cooperation in completing this form thoroughly. Please print legibly.

Health Questionnaire

Name: _____ Age: _____ Date of Birth: _____

Referred by: _____

Reason for visit: _____

Marital Status: [] Single [] Married [] Partnered [] Divorced [] Separated [] Widowed [] Other

Obstetrical History:

How many times have you been pregnant? _____ Number of vaginal deliveries: _____

Number of cesarean sections: _____ Reasons for cesarean: _____

Largest infant: _____ Number of miscarriages: _____ Number of ectopic pregnancies: _____

Number of elective abortions: _____ Premature births: _____ Stillbirths: _____

Any complications during pregnancy? _____

Do you wish more pregnancy? _____ How many children living? _____ Adopted children? _____

Gynecologic History:

Menstrual Periods:

Date of last menstrual period: _____ Was it normal? []yes []no

Are you taking birth control pills? []yes []no Type: _____

Menstrual periods come every _____ days and last for _____ days.

Any recent changes in your periods? []yes []no

If yes, explain: _____

Do you have:

- 1 Excessive pain with your periods? []yes []no
2 Excessive bleeding with your periods? []yes []no
3 Premenstrual symptoms (PMS) []yes []no

If 'yes' to any of above, please explain: _____

Preventative Health:

Pap Smears:

Date of last pap smear: _____ Normal [] Abnormal []

Previous abnormal Pap? []yes []no If 'yes', date: _____

Mammograms:

Date of last mammogram: _____ Normal [] Abnormal []

Do you do breast self exams? yes no

Do you or have you had a breast lump? yes no

Do you have annual check-ups with a family doctor or internist? yes no Date of last visit: _____

Name of physician: _____

Sexuality:

- 1 Are you sexually active? yes no
- 2 Do you have a need for birth control? yes no
- 3 Do you have pain with sexual relations? yes no
- 4 Do you have questions regarding sexuality? yes no

Birth Control:

Current method of contraception (check one): Pill Rhythm Condoms Cervical Cap Diaphragm
Depo Provera Norplant Tubal Sterilization Vasectomy

Are you satisfied with this method? yes no

Other methods previously used: _____

Infections:

Do you have vaginal infections? yes no

If 'yes' explain: _____

Have you ever had a sexually transmitted disease? yes no

If 'yes' (check): Herpes Venereal Warts Chlamydia Gonorrhea Syphilis
AIDS Pelvic Inflammatory Disease other: _____

What was the treatment you were given: _____

Menopause:

Have you stopped having your periods? yes no Date: _____

Have you had a hysterectomy? yes no Date: _____

Surgical removal of ovaries? yes no Date: _____

Do you take hormone replacement therapy? yes no

If "yes" name and how many taken: _____

Have you had any vaginal bleeding since menopause? yes no Date: _____

Do you have: Accidental loss of urine? yes no Vaginal dryness? yes no Pelvic pressure? yes no
Hot Flashes? yes no Pain with intercourse? yes no

Explain any other gynecological problems or questions: _____

Past Medical History:

Allergies: _____

Medications you are taking – including birth control pills:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Operations: (*List Date, Type, Hospital and any Complications*)

1. _____
2. _____
3. _____
4. _____

Medical Illness or Problems (Please list):

1. _____ 3. _____
2. _____ 4. _____

Have you had problems with any of the following conditions?

- | | | | |
|----------------------------------------------|------------------------------------|---------------------------------------|----------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Embolus | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Kidney Disease | | | |

Family History:

Have any of your blood relatives had:

- | | | | |
|----------------------------------------------|------------------------------------------------------------|-------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer (specify) _____ | |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Other Conditions (specify): _____ | | |

Are you adopted? yes no

Review of Systems:

Do you have or have you *ever* had:

- 1 Problems with your eyes, ears, nose, throat? yes no
Explain: _____
- 2 Problems breathing or shortness of breath? yes no
Explain: _____

- 3 Problems with your heart, mitral valve prolapse, rheumatic fever, chest pain
irregular heart beat, or abnormal electrocardiogram? yes no
Explain: _____
- 4 High Blood Pressure? yes no
Explain: _____
- 5 Problems with fibrocystic breast tumors or discharge from your nipples? yes no
Explain: _____
- 6 Problems with your bowels, change in bowels habits, diarrhea, constipation,
hemorrhoids or bleeding with bowel movements? yes no
Explain: _____
- 7 Problems with urination, kidney or bladder infection, or accidental loss of urine? yes no
Explain: _____
- 8 Problems with pelvic pressure, low back pain or a sensation of pelvic organs
failing? yes no
Explain: _____
- 9 Problems with excessive thirst, frequent urination, feeling extremely cold or
lethargic? yes no
Explain: _____
- 10 Arthritis, thrombophlebitis, easy bruising or varicose veins? yes no
Explain: _____
- 11 Change in voice, increased facial or body hair? yes no
Explain: _____
- 12 Depression, anxiety or the need for psychological counseling or psychiatric care? yes no
Explain: _____
- 13 Have you used IV drugs, had a partner who was bisexual or used IV drugs, or had
more than 10 sexual partners in your life? yes no
- 14 Weight change of more than 20lbs. over the past year, or a history of an eating
disorder such as bulimia, anorexia nervosa, or over eating? yes no
Explain: _____
- 15 Abdominal pain, bloating, indigestion? yes no
Explain: _____
- 16 Difficulty sleeping, night sweats? yes no
Explain: _____
- 17 Have you ever had a blood transfusion? yes no
If yes, when?: _____

Social History:

1. Do you smoke? yes no How much? _____ In the past? _____
2. Do you drink alcohol? Rarely Occasionally Daily
Do you have one or more drinks per day? yes no
3. Do you use drugs socially? Rarely Occasionally Often No
If 'yes' then - Marijuana Cocaine Crack Other (explain): _____
4. Do you exercise regularly? yes no Times per week? _____ Type of exercise: _____
5. Last grade of school attended: _____ Occupation: _____

Optional:

Have you been physically or mentally abused by your spouse, partner, parent, etc...? yes no

If 'yes' please explain: _____

Have you been sexually abused or raped? yes no

If 'yes' please explain: _____

How many sexual partners have you had in your life? _____

What is your ethnic background? Caucasian African-American Hispanic Asian Other _____

Do you have any concerns or questions?

Type here: