## **HEALTH HISTORY QUESTIONNAIRE**

1	Concerns:   Conc	Name		v's visit:			
ALLERGIES: Allergy Reaction  1	Reaction	Reaction	Main reason for today	y 5 visit.			
Allergy Reaction  1	Reaction	Reaction  1	Other Concerns:				
1	1	1	ALLERGIES:				
1	1	1.	Allergy		Reaction		
2	2.	2. 3	1				_
PHARMACY:  MEDICATIONS:  Drug Name Strength How is it taken?  1. 2. 3. 4. 5.  PAST SURGICAL HISTORY:  Surgery Reason Year Hospital  1. 2. 3. 4. 4. 5. 5. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6.	HARMACY:    IEDICATIONS:	PHARMACY:  MEDICATIONS:  Drug Name Strength How is it taken?  1.					_
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3.	3	3. 4. 5. PAST SURGICAL HISTORY: PAST SURGICAL HISTORY: PAST SURGICAL HISTORY:  PAST SURGICAL HISTORY:  Problem	1				
4	4	4. 5. PAST SURGICAL HISTORY:  Part Hospital  1. 2. 3. 4. FAMILY HISTORY:  Relation Problem Onset Age Age of Death Notes  Grandmother Grandfather Grand	_				
5. PAST SURGICAL HISTORY: Surgery Reason Year Hospital  1	5.	PAST SURGICAL HISTORY:  Purgery Reason Year Hospital  1 2 3 4  FAMILY HISTORY:  Relation Problem Onset Age Age of Death Notes  Grandmother Grandfather	2.				
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		randfather	3	ORY: Reason Problem	Year FAMILY HISTORY	Hospita	al
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PATIENT NAM	ЛЕ:						
GYNECOLOGI	CAL HISTORY						
Age at first cy	cle:						
Duration of FI	ow (days):						
Date of LMP:							
Menses Mont	thly:						
Frequency of	Cycle (Days): _						
Flow: Light	Moderate He	avy					
Do you have o	cramps? Yes o	r No					
Mild Moder	ate Severe						
Bleeding betw	veen periods o	r after intercour	se? Yes or No	)			
Date of last pa	ap smear (Impo	ortant):	Abnormal F	Pap: Yes or No			
Colposcopy D	ate (If abnorma	al pap):					
Sexually Activ	e? Yes or No						
Current Birth	Control Metho	d:					
HPV Vaccine (	(Gardasil): Yes	or No					
Performs mor	nthly self-breas	t exam?: Yes or	· No				
Date of last N	lammogram: _						
Date of most	recent Bone De	ensity:	_				
If Post-Menop	oausal, age at N	Лenopause:					
Colonoscopy:	Yes or No [	Date of Colonos	сору:	_			
OBSTETRIC H	ISTORY:						
Total Pregnan	nciesAbo	ortionsM	liscarriages	Ectopic	Multiple	Living	
Notes:							
Past Pregnan	cies						
Date	# Fetuses	Gestational age when delivered	Labor Length	Birth Weight	Sex	Delivery Type	Anesthesia Yes or No
-	·	-					<del></del>

Age at First Child: \_\_\_\_\_

PATIENT NAME:				
PAST MEDICAL HISTORY:				
Check all	that apply:			
0	Abuse//Domestic Violence			
0	Acid Reflux (GERD)			
0	Anemia			
0	Anesthesia Complications			
0	Anxiety Disorder			
0	Arthritis			
0	Assisted Reproductive Technology			
0	Asthma			
0	Auto Immune Disorders			
0	Birth Defect or Inherited Disease			
0	Blood Transfusion			
0	Breast Cancer			
0	Breast Problem			
0	Cancer			
0	Depression			
0	Dermatologic Disorders			
0	Diabetes			
0	Eating Disorder			
0	Eczema			
0	Endometriosis			
0	Fibromyalgia			
0	GI Problems			
0	Headaches/Migraines			
0	Heart Disease			
0	Heart Problems			
0	Hematologic Disorders			
0	Hepatitis			
0	High Cholesterol			
0	Hypertension			
0	Infertility			
0	Kidney of Bladder Problems			
0	Liver Disease			
0	Lung Disease			
0	Osteoporosis			
0	Other			
0	Psychiatric Illness			
0	Stroke			
0	Thrombophilia			
0	Thyroid Problems			
0	Uterine Anomaly			
0	Varicosities			

To better service our patients, please provide medical records for only 1 year prior from your previous medical professionals. A medical records release will be provided upon request.

Other concerns not listed: