HEALTH HISTORY QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. All answers are strictly confidential.

Main reason for today's visit: _____

Other Concerns: _____

ALLERGIES:

Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

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. _____			

FAMILY HISTORY:

Relation	Problem	Onset Age	Age of Death	Notes
Mother				
Father				
Siblings				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Maternal Aunt/Uncle				
Paternal Aunt/Uncle				

SOCIAL HISTORY:

Do you smoke? Yes or No If yes, how much do you smoke daily? : _____

Occupation: _____ Education: _____

Live alone or with others? _____ Sexual Orientation: _____ Protected Sex: _____

Alcohol Intake: Moderate Occasional Heavy Caffeine Intake: Moderate Occasional Heavy

Caffeine Intake: Moderate Occasional Heavy

PATIENT NAME: _____

GYNECOLOGICAL HISTORY

Age at first cycle: _____

Duration of Flow (days): _____

Date of LMP: _____

Menses Monthly: _____

Frequency of Cycle (Days): _____

Flow: Light Moderate Heavy

Do you have cramps? Yes or No

Mild Moderate Severe

Bleeding between periods or after intercourse? Yes or No

Date of last pap smear (Important): _____ Abnormal Pap: Yes or No

Colposcopy Date (If abnormal pap): _____

Sexually Active? Yes or No

Current Birth Control Method: _____

HPV Vaccine (Gardasil): Yes or No

Performs monthly self-breast exam?: Yes or No

Date of last Mammogram: _____

Date of most recent Bone Density: _____

If Post-Menopausal, age at Menopause: _____

Colonoscopy: Yes or No Date of Colonoscopy: _____

OBSTETRIC HISTORY:

Total Pregnancies_____Abortions_____Miscarriages_____Ectopic_____Multiple_____Living_____

Notes: _____

Past Pregnancies

Date	# Fetuses	Gestational age when delivered	Labor Length	Birth Weight	Sex	Delivery Type	Anesthesia Yes or No

Age at First Child: _____

PATIENT NAME: _____

PAST MEDICAL HISTORY:

Check all that apply:

- Abuse//Domestic Violence
- Acid Reflux (GERD)
- Anemia
- Anesthesia Complications
- Anxiety Disorder
- Arthritis
- Assisted Reproductive Technology
- Asthma
- Auto Immune Disorders
- Birth Defect or Inherited Disease
- Blood Transfusion
- Breast Cancer
- Breast Problem
- Cancer
- Depression
- Dermatologic Disorders
- Diabetes
- Eating Disorder
- Eczema
- Endometriosis
- Fibromyalgia
- GI Problems
- Headaches/Migraines
- Heart Disease
- Heart Problems
- Hematologic Disorders
- Hepatitis
- High Cholesterol
- Hypertension
- Infertility
- Kidney of Bladder Problems
- Liver Disease
- Lung Disease
- Osteoporosis
- Other
- Psychiatric Illness
- Stroke
- Thrombophilia
- Thyroid Problems
- Uterine Anomaly
- Varicosities
- Other concerns not listed: _____

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.