HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*	**DOB:**
Primary Care Physician:	**PCP's Phone Number:**

Current Pharmacy Name/Address/Phone#:

Does your insurance require mail order prescriptions: YES NO If yes, who is your mail order pharm:

HEALTH HISTORY

List all current prescribed medications and over-the-counter medications, such as vitamins and inhalers:

Medication Name	Strength	Frequency Taken	Reason for medication

MEDICATION ALLERGIES

Medication Name	Reaction you experienced

OTHER ALLERGIES

Do you have a **LATEX** allergy:	If yes, what was your reaction:
Do you have an adhesive allergy (for example, band aids or tape):	
Do you have any food allergies:	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind and how many Drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks/day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit:				
Drugs	Do you currently or have you ever use recreational or street drugs?				☐ Yes	☐ No
	If so, what drug(s)? Last Use:				☐ Yes	☐ No
Sex	Do you currently have a sexual partner? (If you desire, please indicate: male, female, or both)				☐ Yes	☐ No
	Date of the first day of your last period: (if applicable) ____/____/____					
	If you are trying to prevent pregnancy, what method are you using?					
	Physical, sexual and/or mental abuse have also become major public health issues in this country. Do you feel safe at home and work?				☐ Yes	☐ No

NAME:_____

OBSTETRIC AND GYNECOLOGIC HISTORY

Age at first period: Date (or age) of last period:

Number of Pregnancies:_____ Number of live births:_____ Number of Living Children:_____

Your age at your first live birth:_____

Year	Weeks	Gender	Weight	Vaginal or C-section	Any Complications? (ie: Diabetes, High blood pressure, Shoulder dystocia or birth trauma, Preterm labor and delivery, Excessive bleeding or Infection, NICU stay) List any other complications as well

Have you ever had a sexually transmitted infection?	☐ Yes	☐ No
If so, circle type:: Herpes Chlamydia Gonorrhea Trichomonas HPV HIV Syphillis PID (pelvic inflammatory disease)		
Have you ever had an abnormal pap test?	☐ Yes	☐ No
If so, what year? Please circle treatment: None LEEP Cryo(freezing) Cone		
Have you ever used Hormone replacement therapy?	☐ Yes	☐ No
If so, how many years? Please circle type: Estrogen only Estrogen and Progestin		
Have you ever had an Endometrial ablation?	☐ Yes	☐ No
Have you had a Hysterectomy?	☐ Yes	☐ No
Have your ovaries been removed?	☐ Yes	☐ No

SURGICAL HISTORY

YEAR	SURGERY PERFORMED	REASON	PHYSICIAN	HOSPITAL

MEDICAL HISTORY

CHECK IF YOU HAVE EVER HAD:

(include year, if able)

☐ Anemia or Bleeding disorder (Hemophilia or von Willebrands, Blood transfusion)	☐ Hypertension	☐ Fibroids, Endometriosis, Polycystic Ovarian Syndrome (PCOS), Infertility, Uterine Abnormality, PID
☐ Autoimmune problems (Rheumatoid, Lupus, Sjogrens)	☐ Diabetes or Pre-diabetes	☐ DES exposure
☐ Heart problems (Heart Murmur, Heart defect, Heart attack/blockage, Atrial fib or Arrythmia)	☐ Elevated Lipids/cholesterol	☐ DVT/PE or Peripheral Vascular Disease
☐ Stroke, Dementia, MS	☐ Bladder or Kidney problems (Kidney stones, Interstitial cystitis)	☐ Breast Biopsy (# and result:_____)
☐ Depression, Anxiety, Bipolar, ADD/ADHD, Anorexia, Bulimia	☐ Gallbladder or Liver disease	☐ Other Problems not listed above:
☐ Alcoholism, Drug Abuse	☐ Thyroid (Hyperthyroid, Graves, Hypothyroid, Hashimoto's, Nodules)	
☐ Lung Problems (Asthma, COPD, Sleep Apnea)	☐ Skin Problems (Eczema, Psoriasis)	
☐ Cancer (list type and treatment)	☐ Osteoporosis or Osteopenia	
☐ Migraines With or without neurologic symptoms?	☐ Intestinal problems (IBS, Crohns, Ulcerative Colitis, GERD, Ulcers, Colon Polyps, Diverticulosis)	

NAME:_____

FAMILY HEALTH HISTORY

Please include the following: Cancers, Heart attack, Stroke, Diabetes, Hypertension, Cholesterol, Osteoporosis (include any hip fractures of parent), Bleeding disorders, Deep vein thrombosis (DVT) or Pulmonary Embolism (PE), Genetic disorders

Include age of onset, if known where AGE is requested. NOT the current age of family member.

☐ **ADOPTED or UNKNOWN FAMILY HISTORY**

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			**YOUR CHILDREN** ☐ NONE	☐ M ☐ F	
MOTHER				☐ M ☐ F	
YOUR SIBLINGS ☐ NONE	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

NAME:_____