HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS

Name _____ Date _____

DOB _____ Age _____ ❍ Single ❍ Married ❍ Separated ❍ Widowed ❍ Divorced

MEDICAL ILLNESSES

Reason for your visit today – please check any that apply:

❍ Heart Disease
❍ Gall Bladder Disease
❍ Birth Abnormalities (type _____)
❍ High Blood Pressure
❍ Asthma
❍ Depression
❍ Diabetes Mellitus
❍ Cancer (type & year _____)
❍ High Cholesterol
❍ Intestinal Disease
❍ Serious Injury (type & year _____)
❍ Rheumatic Fever
❍ Ulcer
❍ Migraines
❍ Stroke
❍ Psychiatric Care
❍ Blood Disease
❍ Arthritis
❍ Lung Disease
❍ Chickenpox
❍ Mumps
❍ Rubella/German Measles
❍ Measles
❍ Convulsions/Epilepsy
❍ Emphysema
❍ Thyroid Gland Disorder
❍ Pneumonia
❍ Breast Disease
❍ Bronchitis
❍ Blood Clots in Vessels
❍ Any Other - List: _____

SURGICAL HISTORY

Please complete the following about your past surgeries:

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

GYNECOLOGICAL HISTORY

Date of last: ❍ Pap Smear _____ ❍ Pelvic Exam _____ ❍ Mammogram _____

1. Menstrual History / Periods

First day of last period (or date of menopause) _____ Your age when your periods started? _____

Periods occur every _____ days (# of days from the 1st day of one period to the 1st day of the next period - usually every 28 days)

Periods *(check all that apply)* ❍ Heavy? ❍ Regular? ❍ Painful? ❍ Bleed Between Periods? ❍ PMS?

❍ Days of bleeding on period _____ days ❍ Pads/Tampons used _____ / per day

2. History of Sexually Transmitted Diseases (check if positive)

❍ Vaginal Infections
❍ Gonorrhea Infection
❍ Syphilis
❍ Chlamydia Infections
❍ Genital Herpes
❍ Pelvic Infections
❍ Venereal Warts / Condyloma
❍ Oral Cold Sores
❍ Other (type) _____

3. Sexual History / Birth Control

Do you presently practice birth control? ❍ Yes ❍ No If yes, list type and duration _____

Past birth control method(s) / type(s) _____

Sexually active? ❍ Yes ❍ No Pain during intercourse? ❍ Yes ❍ No Sexual Satisfaction? ❍ Yes ❍ No

Frequency of sexual relationships (per month) _____

Prior high risk contacts? (i.e. IV drug users, bisexuals, hemophiliacs, multiple partners) ❍ Yes ❍ No

4. Other Gynelogical Problems? ❍ Yes ❍ No If yes, explain _____

OBSTETRICAL HISTORY

Total Pregnancies _____ Live Births _____ Miscarriages _____ Premature Births _____

Still Births _____ Abortions _____ Cesareon Sections _____

Birth Malformations ❍ Yes ❍ No If yes, list type _____

Pregnancy Complications *(check all that apply)* ❍ High Blood Pressure ❍ Diabetes ❍ Other _____

Children *(list age and sex)*

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____

SOCIAL HISTORY

Employed? ❍ Yes ❍ No Occupation _____

Disabled? ❍ Yes ❍ No If yes, for how long and why? _____

Alcohol? ❍ Yes ❍ No If yes, amount _____ Cigarettes? ❍ Yes ❍ No If yes, amount per day _____

Drug Use? ❍ Yes ❍ No Transfusions? ❍ Yes ❍ No If yes, number and year _____

MEDICATIONS

1. _____ 4. _____

2. _____ 5. _____

ALLERGIES

Medications - Please list name of medicine and your reaction to them.

_____

Environmental? ❍ Yes ❍ No If yes, please list _____ Food? ❍ Yes ❍ No If yes, type _____

FAMILY MEMBERS ILLNESSES - Please also list which family member

❍ High Blood Pressure _____ ❍ Asthma _____ ❍ Diabetes _____

❍ Stroke _____ ❍ Thyroid Disease _____ ❍ Arthritis _____

❍ Psychiatric Care _____ ❍ Heart Disease _____ ❍ Depression _____

❍ Convulsion / Epilepsy _____ ❍ High Cholesterol _____ ❍ Cancer - type _____

❍ Other Disease(s) - explain _____

PRESENT SYMPTOMS - Please check all the apply.

RESPIRATORY
- ❍ Shortness of Breath
- ❍ Chronic Cough
- ❍ Cold Symptoms
- ❍ Wheezing
- ❍ Cough w/ sputum
- ❍ Cough w/ blood

GASTROINTESTINAL
- ❍ Constipation
- ❍ Diarrhea
- ❍ Nausea
- ❍ Vomiting
- ❍ Heartburn
- ❍ Change in Bowels
- ❍ Abdominal Pain
- ❍ Blood in Stools

ENDOCRINE
- ❍ Heat/Cold Intolerance
- ❍ Unexplained Weight Loss
- ❍ Difficulty Swallowing

CARDIOVASCULAR
- ❍ Chest Pain
- ❍ Cyanosis
- ❍ Swelling Hands/Feet
- ❍ Awake at Night w/ Smothering
- ❍ Palpitations

MUSCULOSKELATAL
- ❍ Joint Pain
- ❍ Muscle Pain
- ❍ Back Pain
- ❍ Weakness
- ❍ Hematological
- ❍ Easy Bleeding
- ❍ Anemia
- ❍ Easy Bruising

SKIN
- ❍ Skin Disease
- ❍ Jaundice (yellow skin)
- ❍ Change in Skin Moles

URINARY TRACT
- ❍ Burning while Urinating
- ❍ Involuntary Urine Loss
- ❍ Nighttime Urination > 1
- ❍ Blood in Urine
- ❍ Increased Frequency
- ❍ Difficulty Urinating

NEURO-PSYCHIATRIC
- ❍ Depression
- ❍ Seizures
- ❍ Suicidal Ideas
- ❍ Anxiety
- ❍ Paralysis
- ❍ Hallucinations
- ❍ Trouble Sleeping
- ❍ Difficulty Having Fun

ENT / EYES
- ❍ Glasses
- ❍ Sore Throat
- ❍ Difficulty Hearing

❍ Other issues you would like to discuss _____

Referred by _____