HEALTH QUESTIONNAIRE

Date _____

(The purpose of this questionnaire is to assist the doctor with your care)

Name _____ Age _____ Birth Date _____ Occupation _____

Education _____ Religion _____

Circle: Single, Married (_____years), Widow, Divorced, Separated, Remarried

Date of last Physical examination _____

Circle the **Main** reason you came to see the doctor.

Pain Menstrual Problem Discharge Possible Pregnancy Urinary Problems Birth Control Routine Check Pap Infertility
Other _____

Note: This is part of your medical record and is kept confidential. It will not be released to any person without your written consent.

Please circle YES or NO answers

FAMILY HISTORY	Living age	Living health	Deceased cause
Father			
Mother			
Brothers & sisters 1			
2			
3			
4			
5			
Husband			
Children 1			
2			
3			
4			
5			

Disease in blood relatives (encircle yes or no)			who
Cancer	Yes	No	
Tuberculosis	Yes	No	
Diabetes	Yes	No	
Elevated cholesterol	Yes	No	
Heart trouble	Yes	No	
High Blood Pressure	Yes	No	
Asthma	Yes	No	
Arthritis	Yes	No	
Epilepsy	Yes	No	
Insanity	Yes	No	
Birth defects	Yes	No	
Twins	Yes	No	
Cesarean	Yes	No	
Blood disorders (type)	Yes	No	
Genetic disorders (type)	Yes	No	
Other	Yes	No	

PERSONAL HISTORY

HEIGHT _____

WEIGHT _____ one year ago _____

Maximum _____ when _____

Have you been hospitalized for any illness?

Yes No

Give details _____

_____

PREVIOUS SURGERY Year

Yes No Tonsils
Yes No Appendix
Yes No Gallbladder
Yes No Breast
Yes No Varicose veins
Yes No Hernia
Yes No Laparoscopy
Yes No Dilation & Curettage (D&C)
Yes No Hysterectomy
Yes No Ovaries
Yes No Tubes
Yes No Others: list

Have you ever been advised to have any surgical operation which has not been done?

Yes No

TRANSFUSIONS

Yes No Blood
Yes No Plasma
Yes No Other

ALLERGIES

Yes No Penicillin
Yes No Sulfa
Yes No Tetracycline
Yes No Other Antibiotics
Yes No Codeine
Yes No Novocain/Anesthetics
Yes No Other drugs
Yes No Foods
Yes No Other

DO YOU USE

Yes No Caffeine
Yes No Tobacco
Yes No Alcohol
Yes No Social/recreational drugs

CURRENT MEDICATIONS

Yes No Laxatives
Yes No Vitamins
Yes No Tranquilizers
Yes No Sleeping pills
Yes No Thyroid
Yes No Diet pills
Yes No Water pills
Yes No Heart pills
Yes No Blood pressure pills
Yes No Hormones
Yes No Birth Control
Yes No Aspirin
Yes No Ibuprofen
Yes No Others

CHILDHOOD ILLNESS

Yes No Measles
Yes No Mumps
Yes No Chicken Pox
Yes No Scarlet Fever/Rheumatic Fever
Yes No Rubella (German Measles)

ADULT ILLNESS

Yes No Pneumonia/Bronchitis
Yes No Tuberculosis
Yes No Asthma
Yes No Cancer
Yes No Diabetes
Yes No Arthritis
Yes No Back trouble
Yes No Anemia
Yes No Jaundice, Hepatitis
Yes No Ulcer
Yes No Seizures or convulsions
Yes No Nervous breakdown/Depression
Yes No Phlebitis, blood clot
Yes No Migraine headache
Yes No Varicose veins
Yes No Kidney disease
Yes No Bladder infection
Yes No Gallbladder disease
Yes No Mononucleosis
Yes No Meningitis/Encephalitis
Yes No Heart murmur/MVP
Yes No Heart attack/Angina
Yes No Stroke (CVA)
Yes No Thyroid disease
Yes No Hypertension
Yes No Hemorrhoids
Yes No Endometriosis
Yes No Exposed to or tested positive for HIV
Yes No DES exposure
Yes No Other

(Over)

AS OF NOW DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Please circle YES or NO answers

Appetite changes	Yes	No	Breast lump	Yes	No	Lose urine when you cough or laugh	Yes	No
Weight gain or loss	Yes	No	Breast discharge	Yes	No	Muscle pain or cramping	Yes	No
Fatigue	Yes	No	Breast operations	Yes	No	Pain stiffness or swelling of joints	Yes	No
Skin rash or irritation	Yes	No	Do you do breast self exams	Yes	No	Swelling or water retention	Yes	No
Skin growths	Yes	No	If yes, when & how often?			Pain or decreased motion of back or neck	Yes	No
Sun sensitivity	Yes	No	_____			Dizziness	Yes	No
Change in pigment or color of skin	Yes	No	Chest pain	Yes	No	Loss of consciousness	Yes	No
Headaches	Yes	No	Productive cough	Yes	No	Emotional or psychiatric problems	Yes	No
Visual changes	Yes	No	Cough up blood	Yes	No	Paralysis	Yes	No
Hearing problems	Yes	No	Shortness of breath	Yes	No	Numbness	Yes	No
Ear infections, earaches	Yes	No	Heartburn	Yes	No	Chills or fever	Yes	No
Vertigo	Yes	No	Nausea	Yes	No	Night sweats	Yes	No
Sinus problems	Yes	No	Vomiting (if yes, any blood)	Yes	No	Extreme temperature sensitivity	Yes	No
Nose bleeds	Yes	No	Abdominal pain	Yes	No	Hot flashes	Yes	No
Excessive bleeding from cuts	Yes	No	Diarrhea or constipation	Yes	No	Difficulty sleeping	Yes	No
Bruise easily	Yes	No	Recurrent disease	Yes	No	Nervousness	Yes	No
Sore throat or hoarseness	Yes	No	Rectal bleeding	Yes	No	Depression	Yes	No
Trouble swallowing	Yes	No	Frequency of urination	Yes	No	Excessive worry	Yes	No
Bleeding or sore gums	Yes	No	Painful urination	Yes	No	Hair loss	Yes	No
Recurrent sores in mouth	Yes	No	Blood in urine	Yes	No	Unusual growth of hair	Yes	No
Enlarged glands	Yes	No	Get up at night to urinate	Yes	No			
Breast pain	Yes	No	Sudden urge to urinate right now	Yes	No			

MENSTRUAL HISTORY

Started age _____ regular _____ irregular _____
Average number of days from start of one to start of next period _____
Number of days bleeding lasts _____ Date of last normal period (1st day) _____
Menstrual flow is usually: scant _____ moderate _____ heavy _____; Clots Yes No
Are your periods painful? Yes No If yes, describe _____
Do you ever bleed between periods?
Do you bleed after intercourse or douching?
Is intercourse satisfactory? Yes No Painful? Yes No
Time with present partner _____
Do you get tense before periods?
Do you have any sores or rashes?
Have you ever been treated for pelvic infection before? Yes No
Do you have a discharge? Yes No Color _____ Odor? Yes No
Itch? Yes No
Have you been treated for vaginal infection before?

Yes No Fungus-Yeast
Yes No Trichomonas
Yes No Gonorrhea
Yes No Syphilis
Yes No Herpes
Yes No Venereal warts (HPV)
Yes No Chlamydia
Yes No Gardnerella
Yes No Other

Do you Douche? Yes No How often? _____
Date of last PAP SMEAR _____
Do you have a history of abnormal PAP SMEARS? Yes No If yes, what treatment was used?
Cryosurgery _____
Laser surgery _____
Cone biopsy _____
Electrocautery _____

OBSTRETRICAL HISTORY

How many pregnancies have you had? _____
How many sets of twins do you have? _____
How many children born alive? _____
How many cesarean births? _____
How many premature births? _____
How many miscarriages? _____
How many abortions? _____
How many tubal/ectopic pregnancies? _____
How many stillbirths? _____

CONTRACEPTIVE HISTORY

Are you trying to get pregnant? Yes No
Do you have trouble getting pregnant? Yes No
Do you or your partner use a birth control method? Yes No
Check method:

_____	Natural/Rhythm	_____	Diaphragm
_____	Withdrawal	_____	Cervical cap
_____	Abstinence	_____	IUD
_____	Rubber Condom	_____	Pill
_____	Foam	_____	Norplant
_____	Vaginal suppository	_____	Tubal ligation
_____	Vaginal film	_____	Vasectomy
_____	Sponge	_____	Other

Comments or problems with method: _____

CHILDREN

	Sex	Yr. Born	Mos. of Preg.	Length of Labor	Birth Wt.	Complications
1.						
1.						
3.						
4.						
5.						