

## HEALTH HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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 it is taken
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

### Past Surgical History:

Surgery	Reason	Year	Hospital
1. _____			
2. _____			
3. _____			

### Family History:

Relation	Problem	Onset age	Died of age	Notes
Mother:				
Father:				
Siblings:				
Maternal Grandmother:				
Maternal Grandfather:				
Paternal Grandmother:				
Paternal Grandfather:				
Maternal Aunt/Uncle:				
Paternal Aunt/Uncle:				
Unspecified Relation:				

NAME: \_\_\_\_\_

### Past Medical History

Check all that apply:

- Anxiety Disorder
- Abuse/Domestic Violence
- Acid Reflux (GERD)
- Anemia
- Anesthesia Complications
- Anxiety Disorder
- Arthritis
- Assisted Reproductive Technology
- Asthma
- Auto Immune Disorders
- Birth Defects or Inherited Disease
- Blood Transfusions
- 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 or Bladder Problems
- Liver Disease
- Lung Disease
- Osteoporosis
- Other
- Psychiatric Illness
- Stroke
- Thrombophilia
- Thyroid Problems
- Uterine Anomaly
- Varicosities
- Notes \_\_\_\_\_

### 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

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

NAME: \_\_\_\_\_

### Gynecological History

Age at first cycle: \_\_\_\_\_  
Duration of Flow (days): \_\_\_\_\_  
Date of LMP: \_\_\_/\_\_\_/\_\_\_\_  
Menses Monthly: Y or N  
Frequency of Cycle (days): \_\_\_\_\_  
Flow: Light Moderate Heavy  
Do you have cramps? Y or N  
Mild Moderate Severe  
Bleeding between periods or after intercourse?  
Y or N  
Date of Last Pap Smear (Important):  
\_\_\_/\_\_\_/\_\_\_\_ Abnormal Pap: Y or N  
Colposcopy (If abnormal pap): \_\_\_/\_\_\_/\_\_\_\_  
Sexually Active? Y or N  
Current Birth Control Method  
\_\_\_\_\_  
HPV Vaccine (Gardasil): Y or N  
Performs monthly self-breast exam: Y or N  
Date of Last Mammogram  
\_\_\_/\_\_\_/\_\_\_\_  
Most Recent Bone Density  
\_\_\_/\_\_\_/\_\_\_\_  
If Post-Menopausal, Age at Menopause: \_\_\_\_\_  
Colonoscopy: Y or N if yes: \_\_\_/\_\_\_/\_\_\_\_

### Social History

Do you smoke? \_\_\_\_\_  
If so, how much? \_\_\_\_\_

Occupation: \_\_\_\_\_  
Education: \_\_\_\_\_  
Live alone or with others? \_\_\_\_\_  
Sexual Orientation: \_\_\_\_\_  
Protected sex: \_\_\_\_\_

Alcohol intake:  
Moderate Occasional Heavy  
Caffeine intake:  
Moderate Occasional Heavy

### Immunization History:

Chickenpox: \_\_\_/\_\_\_/\_\_\_\_  
Flu Shot: \_\_\_/\_\_\_/\_\_\_\_  
Gardasil/HPV: \_\_\_/\_\_\_/\_\_\_\_  
Hepatitis A B: \_\_\_/\_\_\_/\_\_\_\_  
Meninococcus: \_\_\_/\_\_\_/\_\_\_\_  
MMR: \_\_\_/\_\_\_/\_\_\_\_  
Pneumonia: \_\_\_/\_\_\_/\_\_\_\_  
TDap: \_\_\_/\_\_\_/\_\_\_\_  
Tetanus: \_\_\_/\_\_\_/\_\_\_\_  
Zostavax (Shingles): \_\_\_/\_\_\_/\_\_\_\_