# 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:

- o Anxiety Disorder
- o Abuse/Domestic Violence
- o Acid Reflux (GERD)
- o Anemia
- o Anesthesia Complications
- o Anxiety Disorder
- o Arthritis
- o Assisted Reproductive Technology
- o Asthma
- o Auto Immune Disorders
- o Birth Defects or Inherited Disease
- o Blood Transfusions
- o Breast Cancer
- o Breast Problem
- o Cancer
- o Depression
- o Dermatologic Disorders
- o Diabetes
- o Eating Disorder
- o Eczema
- o Endometriosis
- o Fibromyalgia
- o GI Problems
- o Headaches/Migraines
- o Heart Disease
- o Heart Problems
- o Hematologic Disorders
- o Hepatitis
- o High Cholesterol
- o Hypertension
- o Infertility
- o Kidney or Bladder Problems
- o Liver Disease
- o Lung Disease
- o Osteoporosis
- o Other
- o Psychiatric Illness
- o Stroke
- o Thrombophilia
- o Thyroid Problems
- o Uterine Anomaly
- o Varicosities
- o 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: ___/___/____

## Immunization History:

Chickenpox: __/__/____
Flu Shot: ___/___/____
Gardasil/HPV: ___/___/____
Hepatitis A B: ___/___/___
Meninococcus: ___/___/____
MMR: ___/___/___
Pneumonia: ___/___/___
TDap: ___/___/____
Tetanus: ___/___/____
Zostavax (Shingles): ___/___/____

## 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