Womens Health Center

HEALTH QUESTIONNAIRE

If you are uncomfortable answering any questions, please leave them blank; you can discuss them with your doctor or nurse.

Today's Date: _____

Date of Last Menstrual Period: _____

Patient Demographics

Name: _____ Date of Birth: _____

Referred by: _____

Reason for visit: _____

Current Medications- Including supplements, vitamins, herbal products, and over-the-counter medication

EXACT NAME OF DRUG	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN

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Please list additional medications on the back of this paper or attach a separate sheet.

Pharmacy

Local: _____ City: _____ Cross Streets: _____

Mail Order: _____

Allergies

DRUG/SUBSTANCE	REACTION

DRUG/SUBSTANCE	REACTION

Social History

Tobacco Use:

Current Everyday Smoker **Current Some Day Smoker** **Former Smoker** **Passive Smoker** **Never Smoker**

Type: **Cigarettes** **Pipe** **Cigars** **Snuff** **Chew**

Pack(s)/day: _____ Years: _____ Date Quit: _____

Patient Name: Date of Birth:

Do you drink alcohol? **Yes** **No** How many drinks per week? _____

Do you use drugs socially? **No** **Yes** Use/week: _____

Type: **IV** **Inhalant** **Pills** **Topical** **Marijuana** **Cocaine** **Meth** **Heroine** **Other:** _____

Are you sexually active? **Yes** **Not Currently** **No** Sexual partners: **Men** **Women** **Both**

What method of contraception are you currently using? _____

What methods of contraception have you previously used (please include name of pills)? _____

_____

Activities of Daily Living

Are you on a special diet? **Yes** **No** If 'yes,' please explain: _____

Do you exercise regularly? **Yes** **No** How many times per week? _____

Do you do self breast exams? **Yes** **No** How often? _____

Socioeconomic

Occupation: _____ Employer: _____

Spouse/Partner's Name: _____ # of children: _____
(Include step and adopted children)

Education: **High School** **Some college** **AA Degree** **Bachelor's Degree** **Graduate Degree** **Other:** _____

Relevant Dates

Date of last Pap Smear: _____ Was it normal? **Yes** **No** If 'no,' please explain: _____

Date of last mammogram: _____ Was it normal? **Yes** **No** If 'no,' please explain: _____

Have you had a bone density study? **Yes** **No** Date: _____ Result: _____

Have you had a colonoscopy? **Yes** **No** Date: _____ Result: _____

Past Medical History

MAJOR ILLNESS	YES (DATE)	NO	NOTES
Asthma			
Pneumonia/Lung Disease			
Kidney Infections/Stones			
Tuberculosis			
Fibroids			
Hypertension			
Elevated Cholesterol			
Eating Disorder			
Autoimmune Disease (Lupus)			
Chickenpox			
Cancer			
Reflux/Hiatal Hernia/Ulcers			
Migraine Headaches			
Hepatitis			

MAJOR ILLNESS	YES (DATE)	NO	NOTES
Anemia			
Blood Transfusions			
Heart Disease			
Bowel Problems			
Seizures/Convulsions/Epilepsy			
Depression/Anxiety			
Glaucoma			
Bladder Problems			
Bleeding Disorders			
Diabetes			
Arthritis/Fibromyalgia			
Thyroid Problems			
Other:			

Do you accept blood transfusions? **Yes** **No**

Patient Name: Date of Birth:

Operations and Medical Procedures- Include colonoscopies

REASON	DATE	RESULTS

Family History

Are you adopted? **Yes** **No**

Does anyone related to you have a history of the following illnesses?

ILLNESS	YES	RELATIVE (Ex. Maternal Aunt)	AGE OF ONSET	ILLNESS	YES	RELATIVE (Ex. Maternal Aunt)	AGE OF ONSET
Alcohol/ Drug				Elevated Lipids			
Anesthesia Problems				Genetic			
Arthritis				Gastrointestinal			
Birth Defects				Heart			
Blood clots in lungs/legs				Hypertension			
Blood Disorder				Osteoporosis			
Cancer:				Psychiatry/Mental Illness/Depression			
Breast				Pulmonary			
Colon				Renal			
Ovarian				Stroke			
Uterine				Tuberculosis			
Diabetes				Thyroid			
Other:							

Obstetrical History

Pregnancy History: **Never been pregnant** **Currently pregnant** **# of times you have been pregnant before? _____**

Number of: **Vaginal deliveries: _____** **C-sections: _____** **Miscarriages: _____** **Ectopic pregnancies: _____**

Elective abortions: _____ **Premature births: _____** **Stillbirths: _____**

Date of Delivery	Gest. Age	Labor Lngth.	Wt.	Sex	Delivery Type (Vag., C-section)	Anesth. Type (Epidural, Spinal)	Name	Location	MD

Any pregnancy complications? **Yes** **No** If 'yes,' please explain: _____

Any history of depression before or after pregnancy? **Yes** **No** How was it treated? _____

Menstrual History

Age periods began: _____ Menstrual periods come every _____ days and last for _____days.

Period pattern is: **Regular** **Irregular** Menstrual flow is: **Light** **Moderate** **Heavy**

Do you have pain with periods? **No pain** **Mild** **Moderate** **Severe**

Pain symptoms: **Cramping** **Throbbing** **Nausea** **Diarrhea** **Headache** **Other:** _____

Do you have premenstrual symptoms (PMS)? **Yes** **No** _____

Gynecological History

Have you ever had an abnormal Pap? **Yes** **No** If 'yes,' explain: _____

Have you ever had a sexually transmitted disease? **Yes** **No** _____

Have you been treated for infertility? **Yes** **No** _____

Do you have any urinary problems? **No** **Loss of urine** **Frequent urination** **Other:** _____

Do you have pain with sexual relations? **Yes** **No** _____

Do you have recurrent vaginal infections? **Yes** **No** _____

IF Menopausal:

When did you stop having periods? _____

Have you used/taken hormone replacement? **Yes** **No** If 'yes,' what type, dose, and when? _____

_____

Have you had any vaginal bleeding since menopause? **Yes** **No** When and how much? _____

Do you have...

Hot flashes?	**Yes**	**No**	Decreased libido?	**Yes**	**No**
Night sweats?	**Yes**	**No**	Anxiety?	**Yes**	**No**
Trouble sleeping?	**Yes**	**No**	Depression?	**Yes**	**No**
Decreased memory?	**Yes**	**No**	Vaginal Dryness?	**Yes**	**No**

Optional

Have you been physically or mentally abused by your spouse or partner? **Yes** **No**

Have you ever been sexually abused or raped? **Yes** **No**

Do you have any other questions or concerns?

_____

_____

_____

_____

Patient Name: Date of Birth:

Review of Systems: Please check if any of the following symptoms apply to you now or since adulthood.

	NOW	PAST	NOTES
1. Constitutional			
Weight loss			
Weight gain			
Fever			
Fatigue			
Change in height			
2. Eyes			
Spots before eyes			
Vision changes			
Double vision			
Glasses/contacts			
3. Ear, Nose, Throat			
Earaches			
Ringing in ears			
Hearing problems			
Sinus problems			
Sore throat			
Dental Problems			
Mouth sores			
4. Gastrointestinal			
Frequent diarrhea			
Bloody stool			
Nausea/vomiting/indigestion			
Constipation			
Involuntary loss of gas or stool			
5. Musculoskeletal			
Muscle weakness			
Muscle or joint pain			
6. Skin			
Rashes			
Sores			
Dry skin			
Moles (growth or changes)			
7. Breasts			
Pain in breasts			
Nipple discharge			
Lumps			
8. Allergic/Immunologic			
Other Allergies:			

	NOW	PAST	NOTES
9. Cardiovascular			
Chest pain or pressure			
Difficulty breathing on exertion			
Swelling of legs			
Bleeding problems			
10. Respiratory			
Painful breathing			
Wheezing			
Shortness of breath			
Coughing up blood			
Chronic cough			
11. Genitourinary			
Blood in urine			
Pain w/ urination			
Strong urgency to urinate			
Frequent urination			
Bulge/pressure in vagina			
Involuntary/unintended urine loss			
Urine loss when coughing			
12. Endocrine			
Hair loss			
Heat/cold intolerance			
Abnormal thirst			
Hot flashes			
13. Neurological			
Dizziness			
Seizures			
Numbness			
Trouble walking			
Memory problems			
Frequent headaches			
14. Psychiatric			
Depression or frequent crying			
Anxiety			
15. Hematological/ Lymphatic			
Frequent bruises			
Cuts do not stop bleeding			
Enlarged lymph nodes (glands)			

We appreciate the time and effort you have taken to complete this questionnaire.
Thank you!

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