HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

☐ Relationship

Age: _____ Marital Status: ☐ Single ☐ Married (How many Years: _____) ☐ Divorced ☐ Widowed

Reason you came to see the doctor: _____

List any Medication you are ALLERGIC to:

_____

_____

Circle any Medical Problem that applies to you:

High Blood Pressure Heart Disease Diabetes
Asthma/Lung Disease Kidney Disease Bleeding Disorder
Breast Disease Cancer Depression/Mental Illness

Other/Remarks: _____

List Medicines you are currently taking:

_____

_____

_____

List any OPERATIONS you have had and the year it took place:

_____

_____

_____

Sexually Active: ☐ No ☐ Yes ☐ With Men ☐ With Women ☐ With Both

Menstruation: Started at age _____, Number of days from start of one period to start of the next period _____ .
Number of days period lasts _____ . Date of last normal menstrual period (1st day) _____ .

Obstetrical History: How many times have you been pregnant? _____ .
How many Full-term babies? _____ , Premature? _____ , Miscarriages? _____ , Abortions? _____ .

Date of Birth	Weeks Pregnant	Weight	Sex M/F	Type of Delivery (Vaginal, C-section, Forceps, ...)	Place/Doctor	Complications?/Remarks?

Last Pap Smear: _____ Results: _____ Any History of Abnormal Pap Smear? _____

Do you smoke? If so, how much per day? _____. Do you drink? If so, how much per week? _____.

Please circle YES after the following questions if they apply to you

Are your periods irregular? YES
Are they painful? YES
Do you bleed between periods? YES
Is intercourse painful/uncomfortable? YES
Are you troubled with a vaginal discharge? YES
Does it itch or irritate you? YES
Do you urinate too often? YES
Do you get up at night to urinate? YES
Do you pass blood in the urine? YES
Do you lose urine when you cough, laugh or sneeze? YES
Does it feel like anything is pushing out of your vagina? YES
Are you constipated? YES
Do you have difficulty with your bowels or bladder YES
Do you have blood in your stools? YES
Have you gained or lost weight? YES

Is your appetite poor? YES
Do your ankles swell? YES
Do you have varicose veins? YES
Do you get shortness of breath? YES
Do you get chest pain? YES
Do you get hot flashes? YES
Do you get headaches? YES
Do you sleep poorly? YES
Have you ever had a blood transfusion? YES
Are you depressed? YES
Have you ever been treated for nerves? YES
Have you ever been hospitalized for anything else? YES

REMARKS: _____

_____

_____

_____

Current age of Mother (or age died & cause): _____ Father: _____

Record Family History of any medical problems including Heart Disease, Diabetes, Cancer, Birth Defects, etc. _____

_____